State of Vermont **AGENCY OF HUMAN SERVICES**

OFFICE OF VERMONT HEALTH ACCESS
103 South Main Street
Waterbury, VT 05671-1201

Report

Health Access Oversight Committee

Pharmacy Benefit Management Program

Behavioral Health Drug Management Plan

September 1, 2005

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Summary

Background and Introduction

In 2002, the General Assembly adopted legislation (No. 127 of the Acts of 2001 Adj. Sess. (2002)) authorizing a prescription drug cost containment program. The legislation authorized the Office of Vermont Health Access to create a Preferred Drug List (PDL), and a prior authorization (PA) program for non-preferred drugs. The Preferred Drug List is created based on the review and recommendations of the Drug Utilization Review (DUR) Board, a group made up of Vermont practicing physicians and pharmacists (see Attachment A for current Board membership).

The legislation, however, exempted from the prior authorization program prescription drugs prescribed for the treatment of severe and persistent mental illness (SPMI) including schizophrenia, severe depression, or bipolar disorder. This is referred to as the "SPMI exemption". To implement this particular provision, the Drug Utilization Review (DUR) Board created a Psychotropic Subcommittee to formulate recommendations as to how to define individuals and drugs covered by the exemption. This led to the creation of the 2002 exemption criteria which were agreed to by the Board and implemented by the OVHA as part of the prior authorization process (see Attachment B).

The exemption was scheduled to sunset on July 1, 2004, but was renewed until July 1, 2005. The State Fiscal Year 2006 Budget Act set provisions to permit the inclusion of behavioral health drugs in the Medicaid Preferred Drug List. The provisions are as follows:

> "(2)(A) The exemption of certain classes of drugs used to treat certain types of severe and persistent mental illness from inclusion in the prior authorization process may end after the review of the report required in Sec. 5(2)(B) of No. 127 of the Acts of the 2001 Adj. Sess. (2002) as amended by Sec. 128h of No. 122 of the Acts of the 2003 Adj. Sess. (2004) and Sec. 310 of this act is completed, the proposed changes to the preferred drug list have been reviewed by the drug utilization review board, and the health access oversight committee has made any recommendations to the drug utilization review board no later than September 15, 2005." (Act 71, Section 305)

Behavioral Health Drugs

Behavioral health drugs comprise twenty-eight separate drug classes (see Attachment C). Behavioral health drug spending in SFY 2005 was $60.4 million, and represented 31.7% of total drug spending of $190.7 million. More significantly, behavioral health drug spending increased by 22.9% between FY 2004 and FY 2005. Approximately 27% of beneficiaries are affected by the SPMI exemption, and about 48% of drug spending for these beneficiaries is for behavioral health drugs. At this point in time, all other major cost categories of drug treatment are subject to program management.

Drug coverage management, although not new in the private sector, is relatively new in the Medicaid arena. Medicaid drug management strategies have grown steadily as drug costs have continued their relentless increase well above the rate of inflation. Vermont was one of the first states to create a preferred drug list (Florida, Michigan, California were earlier). A recent survey identified twenty-nine states with operational PDLs. Some states, like Michigan and Montana, have not exempted behavioral health drugs from their PDLs, but Michigan and other states have included provisions to moderate the impact of prior authorization and address concerns of the advocacy community, by "grandfathering" coverage of existing patients. Other states have exempted behavioral drugs (like Vermont) or have implemented voluntary programs to encourage clinically appropriate, but cost-effective drug prescribing. An example is promotion of the use of the Texas Medication Algorithm Project (TMAP), which creates a clinical map that guides choices of behavioral health drugs (see sample in Attachment D). Ohio, Missouri, and Maine have applied variations of this approach. In a 2002 survey, the Kaiser Family Foundation identified ten states that required prior authorization for anti-depressants, and eleven for benzodiazepines/tranquilizers. Oregon has established the Oregon Evidence Based Practice Center which researches drug efficacy and makes practice recommendations based on clinical evidence. However, compliance with the Center's drug use recommendations is voluntary.

An apparent key in the effectiveness of state initiatives is the extent to which they rely on voluntary compliance. Unfortunately, voluntary compliance generally produces less than satisfactory results from the perspective of State expenditures. For example, drug spending trends for behavioral health drugs in Ohio increased by 128% from 2002 to 2003, and increased another 24% in 2005. Likewise, behavioral health drug spending increases in Florida, which are not covered by their PDL, increased over 35% annually from 2000 to 2002, compared to about 11% for all other drug categories. In Oregon, compliance with the PDL is voluntary and mental health drugs are exempt, and as structured, it is reported that it has done nothing to curb drug spending. Missouri's behavioral health drug management program is funded by Eli Lilly and is based on a voluntary compliance and education model managed by Comprehensive NeuroScience (CNS). It has had more positive results. It was examined independently by Mercer Human Resource Consulting. Their analysis identified decreases in spending trends in several behavioral health drug categories, but it was unclear whether the CNS interventions or other factors were affecting the trend in the categories studied.

Overview of Process

Under Act 71, any proposal to manage SPMI drugs is subject to the review of the DUR Board.

To implement the provision contained in the budget act, the OVHA solicited initial input and advice from the DUR Board's Psychotropic Subcommittee. The Subcommittee met on August 9, 2005 and agreed that effective medication management of behavioral health drugs could include a preferred drug list; prior authorization; grandfathering of current recipients with a diagnosis of schizophrenia, schizo-affective disorder, bipolar affective disorders and severe depression; and managing utilization by improving quality of care (see Attachment E for meeting minutes).

The OVHA also distributed a survey soliciting the opinions of psychiatric practitioners and others on proposed behavioral health drug management options. Included were questions on:

expansion of the PDL to cover behavioral health drugs; expanded use of generic alternatives; use of prior authorization to limit the off-label use of behavioral health drugs; requiring prior authorization to obtain coverage of non-preferred drugs; expedited prior authorization for specified patients; addition of step therapy edits (requiring use of one drug before another is tried in a new patient); limiting use of non-preferred drugs to an initial trial period; clinical detailing; using claims history to identify issues of poly pharmacy or off-label use; reviewing best clinical practice guidelines and intervening when variances are identified; and any other ideas or recommendations that might be made by the respondents. Sixteen individuals responded (see Attachment F for the survey and a summary of the responses).

The DUR Board met on August 16, 2005 to review the extensive materials prepared by the OVHA and First Health Services Corporation, the OVHA's pharmacy benefit manager. The material discussed or reviewed by the Board included:

- an analysis of prescribing patterns;
- expenditure and utilization trends (see analysis description in Attachment G and data in Attachment H);
- literature;
- algorithms;
- options in lieu of formularies/preferred drug lists/prior authorization; for example, the Missouri retrospective review project;
- testimony regarding clinical efficacy and outcomes;
- proposed revisions to the PDL regarding drugs used to treat mental illness; and
- an analysis of assurances that a beneficiary in treatment is not required to change medication such that there would be a risk of psychiatric destabilization.

The material and review resulted in the recommendations that are detailed in the following report section. The Board is planning on meeting on September 20th to consider any recommendations adopted by the Health Access Oversight Committee.

Board Recommendations

The DUR Board agreed that behavioral health drug classes for those with SPMI could be managed using the PDL. The proposed PDL identifies the most clinically appropriate, cost-effective drugs in specified classes. These drugs include generic equivalents and alternatives, as well as other low cost alternatives. More expensive behavioral health drug alternatives will be available with prior authorization using criteria developed through literature review of acceptable standards, particularly the Texas Medication Algorithm Project (TMAP), the International Psychopharmacology Algorithm Project (IPAP), the Oregon Evidence Based Practice Center, the Veterans' Administration, and the Micromedex® Health Series. Whenever possible, the prior authorization process will use the claims processing systems to review the patient's history to determine whether the patient meets the established criteria for approval of the request. This will minimize the impact on the patient and the prescriber community.

The Board also recommended that certain beneficiaries' active treatment be grandfathered so as not to risk destabilization. Only one drug in the newly managed classes may not be

grandfathered. The Board determined in the May 2005 DUR Board meeting that Lexapro® should no longer be a preferred agent and grandfathering was not necessary. Otherwise, patients of any age currently using antipsychotics, antidepressants, and/or mood stabilizers will continue to use their existing drug therapy. Lapses in treatment of four months or longer or changes in treatment will result in the application of the PDL and its clinical criteria.

In addition to the PDL, the Program will simultaneously monitor best practice reports; track utilization; explore prescribing options (for example; dose optimization, pill splitting, etc); and partner with contractors, prescribers, and insurers in educational and detailing activities including Missouri-like approaches, which encourage prescribers to follow published standards, measure conformance with the standards, and follow with targeted prescriber education where there are variations in prescribing compared to the standards.

The following sets out in more detail the recommendations of the OVHA following the discussion and adoption of these recommendations by the DUR Board:

1. Certain patients on existing behavioral health drugs will be "grandfathered". The Board recommended that, with the management of behavioral health drugs, specified beneficiaries' active treatment be grandfathered so as not to risk destabilization. These are patients of any age currently using antipsychotics, antidepressants, and/or mood stabilizers. The Board and the OVHA are cognizant of the risk to these patients who have been stabilized on existing behavioral health medications. They will not be subject to the product selection provisions of the preferred drug list as it relates to their behavioral health drugs (see Lexapro® exception below). This recommendation responds to the statutory provision in the Budget Act that states

> "…The proposed changes to the preferred drug list shall ensure that adults with severe and persistent mental illness and children with a severe emotional disorder receiving pharmaceuticals under Medicaid or a state pharmaceutical program subject to subchapter 5 of chapter 19 of Title 33 prior to the end of the exemption shall receive the same pharmaceuticals without following the new rules or procedures if:
>
> (i) the individual is at risk of psychiatric destabilization from changing to a therapeutically comparable pharmaceutical; and
>
> (ii) the risk is certified in a manner established by the drug utilization review board."

2. The Preferred Drug List will include behavioral health drugs and criteria will be established for their management. The DUR Board adopted recommended changes in the PDL to include preferred behavioral health drugs. The PDL identifies both preferred and non-preferred agents (see Attachment I). Although all drugs currently covered by Medicaid will be available, non-preferred drugs will only be available with prior authorization. The PDL will apply to patients who are newly diagnosed with a behavioral health problem who do not currently have a prescription for one of the covered drugs. Also included will be patients who have had a lapse in behavioral health drug therapy of four (4) or more months. A prescriber may request continuation of the lapsed therapy if the patient has been receiving their medications through an alternative process than the OVHA system. Otherwise the Board believes that this length of time would be sufficient to warrant a trial using the preferred agents on the PDL.

Patients of any age currently using anti-psychotics, antidepressants, and/or mood stabilizers will be grandfathered on their existing drug therapy (see Lexapro® exception below).

In its deliberations on the PDL, the Board reviewed the clinical criteria (see Attachment J) that would be used in reviewing drugs in these classes. The proposed PDL represents a clinically effective array of behavioral health products that are the least costly. Many of these classes are currently represented on the existing PDL with few drug changes. The difference is in the degree of management.

The behavioral health classes of the PDL will include the following:

- SSRIs (Antidepressants);
- Tricyclic Antidepressants
- Antihyperkinesis drugs (ADD/ADHD)
- Novel Antidepressants
- Atypical Antipsychotics
- Typical Antipsychotics (this class is primarily generics)
- Sedative Hyponics
- Anxiolytics
- CNS Agents

The CNS Stimulant category is currently part of the PDL. With the elimination of the SPMI exemption, including the exemption based solely on age, the CNS Stimulant class will now apply to children. The current PDL for this class includes an extensive array of both brand and generic products.

3. The Preferred Drug List for behavioral health drugs will include provisions for maximum dose levels. With some minor exceptions, the Board recommended that prior authorization be required if FDA maximum recommended daily dose levels were exceeded by 25%. For example, Fluoxetine (generic Prozac) has a recommended maximum daily dose of 80 mg. The usual target daily dose is 20 mg. If a prescription was written for a daily dose of more than 100 mgs, a prior authorization would be required to determine the clinical justification for such a high dose. The dosage guidelines are included in the clinical criteria for each group of drugs (see Attachment J).

4. Patients currently on Lexapro® should be switched as soon as possible to generic alternatives. Lexapro® is an antidepressant in a class with multiple generic alternatives available. It was reviewed by the DUR Board in their May 2005 meeting and it was determined at that time that it should no longer be preferred.

5. The Board recommends dose consolidation whenever possible. This recommendation is applicable to all drugs, not exclusively behavioral health drugs. Because of manufacturer pricing practices, one daily dose is almost always less costly than taking the same product in smaller doses two or three times daily (see Attachment K for sample price chart). Daily dosing generally represents best practice as it can result in higher levels of compliance with the therapy, as it is less likely that doses will be forgotten. The Board believes that whenever possible, prescriber

and patient education should encourage dose consolidation. In addition, the OVHA will explore the extent to which the claims processing system can be modified to support dose consolidation.

In support of this, OVHA recommends that consideration should be given to legislation that would allow a pharmacist to dispense a drug in a consolidated dose unless the prescriber specifically requested that consolidation not occur. Pharmacists are currently prohibited from dispensing consolidated doses. This legislation would be conceptually similar to the current generic drug law that requires a pharmacist to dispense a generic drug (if available) unless the prescriber specifies that only a brand drug be dispensed. For example, if this change were made, a daily dose of 20 mg could be dispensed as one daily pill of 20 mg, rather than two 10 mg pills, unless the physician specified otherwise on the prescription.

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Attachment A
DUR Board Members

Drug Utilization Review Board
Members
September 1, 2005

- James A. Gray, Chair, M.D., Family Practice
- Cheryl A. Gibson, M.D., Obstetrics and Gynecology
- Virginia L. Hood, M.D., Nephrology, Internal Medicine
- Stuart Graves, M.D., Psychiatry
- Frank J. Landry, M.D., Internal Medicine
- John R. Low, R.Ph., Pharmacist
- Andrew C. Miller, R.Ph., Pharmacist
- Michael Scovner, M.D., Internal Medicine, Pediatrics
- Lloyd (Tim) L. Thompson, M.D., Family Practice
- Norman S. Ward, M.D., Family Practice
- Rich Harvie, R.Ph., Pharmacist

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Attachment B
2002 Exemption Criteria for Severe and Persistent Mental Illness

2002 Criteria for the Exemption from Management of Drugs Used to Treat People with Severe and Persistent Mental Illness

The criteria for exemption are as follows:

- Patient is diagnosed with schizophrenia or bipolar disorder.
- Patient is diagnosed with an ICD 9 mental health or substance abuse diagnosis (including major depression) (290.00 - 319.00) **and** has or has had a history of impairment due to the mental illness that affects his/her ability to function such that the patient is suicidal, has no friends, neglects family, is unable to work or keep a job, is withdrawn to home or room, stays in bed all day, becomes violent or has even lesser degrees of functioning (Global Assessment of Functioning Scale score of 50 or less). Patient is a past or current user of traditional or atypical antipsychotic medication.
- Patient has received chronic therapy with any antidepressant medication (received at least 300 days supply of medication during a 365 day period).
- Patient has received chronic therapy with any central nervous system stimulant medication (received at least 240 days supply of medication during a 365 day period).
- Presence of a CRT code in eligibility file.
- Patients less than 18 years of age.

An individual found exempt at any time based on one or more conditions other than age has continued to remain exempt even if the exempting condition no longer applies; for example, the patient is no longer taking a qualifying medication.

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Attachment C
Behavioral Health Drug Classes

Behavioral Health Drug Therapeutic Classes

H2A	Central nervous system stimulants
H2D	Barbiturates
H2E	Sedative-hypnotics, non-barbiturate
H2F	Anti-anxiety drugs
H2G	Anti-psychotics, phenothiazines
H2M	Anti-mania drugs
H2S	Selective serotonin reuptake inhibitors (SSRIs)
H2U	Tricyclic antidepressants and related non-selective reuptake inhibitors
H2V	Treatment for attention deficit-hyperactivity (ADHD)/narcolepsy
H2W	Tricyclic antidepressants /phenothiazine combinations
H2X	Tricyclic antidepressants /benzodiazepine combinations
H4B	Anticonvulsants
H7B	Alpha-2 receptor antagonist antidepressants
H7C	Serotonin-norepinephrine reuptake-inhibitors (SNRIS)
H7D	Norepinephrine and dopamine reuptake-inhibitors (NDRIS)
H7E	Serotonin -2 antagonist / reuptake-inhibitors (SARIS)
H7J	MAOIS – non-selective & irreversible
H7O	Anti-psychotics, dopamine antagonist,butyrophenones
H7P	Anti-psychotics, dopamine antagonist, thioxanthenes
H7R	Anti-psychotics, dopamine antagonist, diphenylbutylpiperidines
H7S	Anti-psychotics, dopamine antagonist, dihydroindolones
H7T	Anti-psychotics, atypical, dopamine, & serotonin antagonists
H7U	Anti-psychotics, dopamine, & serotonin antagonists
H7W	Anti-narcolepsy & anti-cataplexy, sedative-type agonists
H7X	Anti-psychotics, atypical, D2 partial agonist/5HT mixed
H7Y	Treatment for attention deficit-hyperactivity (ADHD), NRI-type SSRI & anti-psychotics, atypical, dopamine, & serotonin antagonists
H7Z	combinations
J5B	Adrenergics, aromatic, non-catecholamine

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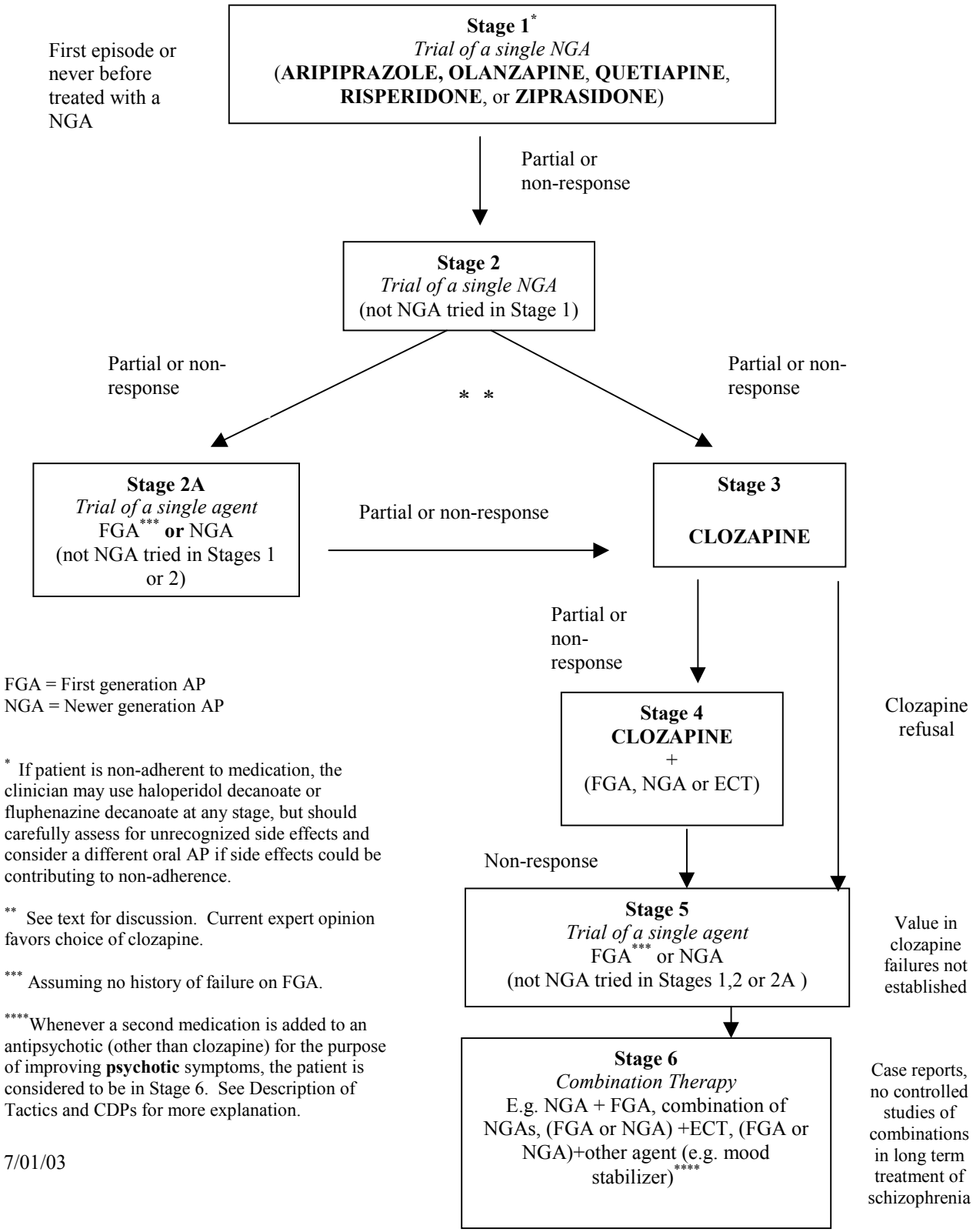
Attachment D
Sample Algorithm: Texas Implementation of Medication Algorithm (TIMA)

As found at http://www.ohiomap.org/algorith_available.asp.

TIMA Antipsychotic Algorithm (2003)

Choice of antipsychotic (AP) should be guided by considering the clinical characteristics of the patient and the efficacy and side effect profiles of the medication.

Any stage(s) can be skipped depending on the clinical picture or history of antipsychotic failures.



FGA = First generation AP
NGA = Newer generation AP

* If patient is non-adherent to medication, the clinician may use haloperidol decanoate or fluphenazine decanoate at any stage, but should carefully assess for unrecognized side effects and consider a different oral AP if side effects could be contributing to non-adherence.

** See text for discussion. Current expert opinion favors choice of clozapine.

*** Assuming no history of failure on FGA.

****Whenever a second medication is added to an antipsychotic (other than clozapine) for the purpose of improving **psychotic** symptoms, the patient is considered to be in Stage 6. See Description of Tactics and CDPs for more explanation.

7/01/03

Report
Health Access Oversight Committee
Pharmacy Benefit Management Program
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Attachment E
Minutes: DUR Psychotropic Subcommittee – August 9, 2005

Office of Vermont Health Access
Pharmacy Benefit Management Program
DUR Psychotropic Subcommittee Meeting
August 9, 2005 4:00-6:00 p.m.
Washington County Mental Health Center, Berlin, VT (also by teleconference)

Committee Members:		
Frank Kalibat, M.D., Acting Chair	John Matthew, M.D.	Bill McMains, M.D.
Stuart Graves, M.D. (DUR Board)	David Fassler, M.D. (phone)	
Staff:		
Ann Rugg, OVHA	Janice VanDyke Corsones, FHSC	Nancy Davis, FHSC (phone)
Kathy Rainville, OVHA	Felicia Montineri, R. Ph., FHSC	

Guests:		
David Anderson, Astra Zeneca	Jim McGrory, Ph.D., Astra Zeneca	Tracy Belnasscort, Astra Zeneca
Parshotum Sachdeun., Astra Zeneca	Susan Gretkowski, MacLean, Meehan and Rice	Lila Richardson, Vermont Coalition for Disability Patients
Paul Kelly, Janssen	Tamara Muse, Abbott	Stephanie Parker, Wyeth
Nina Thomas, Eli Lilly	Vince Matteo, Eli Lilly	Jerry Gressel, NAMI-Vermont
Mike Finn, Glaxo Smith Kline	Judy Kando, Ortho McNeil Janssen	Anne Donahue, Vermont Legislature

Frank Kalibat, M.D., Acting as Chair, called the meeting to order at 4:05 p.m. at Board Room of the Washington County Mental Health Center in Berlin, VT. A meeting attendance sheet and opportunity for public comment sign-up sheet were circulated.

1. <u>INTRODUCTIONS</u>:

Introductions were made of those present and participating via conference call.

2. <u>CHARGE FROM THE DUR BOARD</u>:

The DUR Board has asked the Psychotropic Subcommittee to:
- review and comment on draft documents :
  - Behavioral Health PDL
  - Behavioral Health Initiative – Options for Clinical Management
- review and comment on The Behavioral Health Medication Survey Tool and responses.

Dr. Kalibat requested the drug company representatives in the room bring back a message to their companies the need to discontinue raising the prices of prescription drugs. Subcommittee members expressed great concern about the impact of the Medicare Part D to dual eligible beneficiaries and the burden of choice they have regarding choosing a pharmacy benefit plan and the effect this will have on their treatment plans. Although the Agency of Human Services has formed a group to provide educational information to assist Medicare eligible beneficiaries choose the most appropriate coverage to meet their individual needs, the Subcommittee stressed the importance that provider information needs to be disseminated in a timely fashion.

3. SURVEY TOOL AND RESPONSES: JULY 2005

OVHA sent surveys to 70 prescribers, beneficiaries and interested parties. The seven responses received to date were shared. After discussion, the subcommittee recommended that the Vermont Medical Society (VMS) send this survey out to members of the psychiatric list serve via email.

Survey topics:

-Behavioral Health Preferred Drug List (PDL)
-Generic Trials
-Criteria for Behavioral Drugs for Behavioral Drug Use
-Prior Authorization
-Expedited Prior Authorization
-Claims Applied Step Therapy Edits
-Non-Preferred Drug Trials
-Clinical Detailing
-Patient Look Back
-Best Clinical Practice Review

The Subcommittee agreed that the survey tool was helpful. Respondents raised concerns about the importance of maintaining patients' stability and that educational efforts were very important. A best practice approach such as the Missouri Approach would be beneficial to identify areas within practice and prescribing parameters for quality improvement.

Public Comment:
Vince Matteo, Eli Lilly, commented on the effectiveness of the Missouri Approach which is purported to have saved millions of dollars.

4. BEHAVIORAL HEALTH MEDICATION INITIATIVE: PDL Draft and General Clinical Management Options:

The proposed Behavioral Health Preferred Drug List includes the following classes and specific medications for inclusion.

Novel Antidepressants: Currently a managed class on the Vermont PDL. No changes.

SSRI and Combos: Currently a managed class on the Vermont PDL.
Recent change:

Lexapro® was moved to non-preferred status, leaving a solely generic preferred list.

Reasons for prescribing non-preferred brand drugs were reviewed (i.e., Zoloft® for pregnant and lactating patients) concluding that ongoing education and literature review are important.

Tricyclic Antidepressants: Currently a managed class on the Vermont PDL.

Antihyperkinesis (ADD/ADHD, Narcolepsy): Currently a managed class on the Vermont PDL.
Recent changes include:

Concerta®(methylphenidate specialty) - The one year grandfathering period as of 7/1/04 has expired. A Prior Authorization is now needed for Concerta®

Focalin XR®(dexmethylphenidate specialty) is proposed to be included as a preferred product.

Atypical Antipsychotics and Combinations: New class to be managed on the Vermont PDL.

Proposal:
First line agents: Risperdal® and Seroquel® do not require prior authorization.
Abilify®, Geodon®, Risperdal Tab Rapidis® and Consta®, Symbyax®, Zyprexa®, Zyprexa IM® and Zydis® require PA.
Second line agent: Clozapine generic trial before brand Clozaril® agents.

The Subcommittee recommended that one generic of Clozapine be selected to minimize registry changes and therapeutic interchange.

Sedative Hypnotics: Currently a managed class on the Vermont PDL. No changes.

Anxiolytics: Currently a managed class on the Vermont PDL. No changes.

Behavioral Health Medications not on the PDL.

Typical Antipsychotics: Generally available as generic.
Monoamine Oxidase Inhibitors: Generally available as generic.

Classes to have clinical criteria or prerequisite therapies:

Anti-narcolepsy/Cataplexy: Xyrem® (sodium oxybate)
Mood Stabilizers: carbamazepine, divalproex sodium, gabapentin, lithium carbonate, lamotrigine, oxcarbazepine and topiramate.

The Subcommittee agreed to recommend the use of available generics before brand agents. Concern was expressed that patients identified with severe and persistent mental illness and currently stable on a specific drug therapy should be grandfathered. The dose optimization and 'look-back' claims review management tools were well received. All areas where savings could be found without destabilizing patients were encouraged.

5. NEXT STEPS:

The Subcommittee agreed that prescriber education was essential. Suggested key components include:

Dose Optimization and Dose Consolidation information be redistributed.
Clinical Detailing by clinically credentialed personnel, in a physician's habitat, presented in a palatable and useful format.
Partnering with the Vermont Medical Society using their newsletter as a method of publicizing.
Grand Rounds at hospitals, Credentialed Speakers at medical meetings.
Distribution of pill splitters, paid for by OVHA.
Education on taper regimens and dosage crosswalks for medication changes.
RetroDUR

Committee Recommendation to the DUR Board**:** The Psychotropic Subcommittee agreed that effective medication management of Behavioral Health medications would require all four of the tools proposed which include:

~ A Preferred Drug List.
~ Prior Authorization.

~Grandfathering current recipients with a diagnosis of schizophrenia, schizo-affective disorder, bipolar affective disorders and severe depression.
~ Managing Utilization by Improving Quality of Care.

6. ADJOURN:

The meeting adjourned at 6:00 p.m.

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Attachment F
Practitioners Survey and Responses

OFFICE OF VERMONT HEALTH ACCESS
Pharmacy Benefit Management Program
Behavioral Health Drug Management Plan
Medication Management Tools Survey
August 2005

RESPONSES

Each individual's responses are numbered (all responses numbered "1" are those of individual "1", all responses numbered "2" are those of individual "2", all responses numbered "3" are those of individual "3", etc.); not everyone responded to each section.

Behavioral Health Preferred Drug List (PDL) – The existing Preferred Drug List (PDL) would be expanded to identify behavioral health drugs that ensure quality of care in the most cost effective manner possible. Preferred drugs would have to be trialed before comparative non-preferred drugs could be selected. Drugs would be non-preferred because they require clinical oversight or because they are significantly more costly.

Comments:

1. If a patient has been stabilized on a "non-preferred drug" such as Clozapine, then it would be highly risky to tamper with the current medications and force a new "trial" of lower cost "preferred" drugs.
My daughter (who has schizoaffective disorder diagnosed before she turned 18, in spring 2001) has been stable on Clozapine for four years. It was after a 2 hospitalizations of multiple weeks each at the Brattleboro Retreat, trialed unsuccessfully on four other drugs (Risperdal, Seroquel, Geodon, Lithium) that did not work for her, that finally Clozapine was ordered and began to clear her mind of psychotic and suicidal symptoms. She has gradually been assuming more independence, but continues to need a lot of support, and has not been able to support herself. She is on Social Security Disability and since she has been disabled for over 2 years, has Medicare as well as Medicaid. I have chosen to keep her on my family medical plan and have had to actively advocate with MVP (and previously BC/BS of VT) to keep her on my benefit as a disabled adult child. Presently Medicare and Medicaid pay very little. But that could change. If MA was her only payor and, under this new proposal, she were to be forced to undergo a new trial of a cheaper "Preferred medication", she could decompensate and the outcomes she has achieved under Clozapine, ***might never be achieved again***. I have read that this is a great danger for patients who are stable on a medication. If they go off the med that is working, that they may never get therapeutic results on it again after a break in the regimen.

2. I understand the benefits of a PDL for most common illnesses. In the case of MI, as a family we have withstood 4 hospitalizations and years of balancing zombie like behavior with desperate suicidal illness. Now that better medications are available, and my son and grandson are stable, I am totally unwilling to think that we need to go back to twenty years of being on continual family watch, without the background to really help. Less community support is available from the Howard Center due to high case manager turnover, and increasingly higher caseloads. My son lives in a SRO, with minimal staffing with other very ill consumers in the building**.**

3. There may be some fall out transferring clients who are stable on expensive medication to generics with significant side effects. The newer agents are being used because they are efficacious with less side effects**.**

4. Overall, this seems reasonable**.**

5. Even though the wording of this proposal is redolent with unfounded bureaucratic optimism (i.e., "drugs that ensure quality of care," as if any drug can ensure this), the idea is no more unreasonable than any other idea if one is speaking of previously untreated patients. A previously treated patient needs to have direct access to the medication that has successfully treated him/her without being forced to try a "preferred" drug first**.**

6. This is an unacceptable infringement on the needs of persons diagnosed with severe and persistent mental illness. The illness itself can cause cognitive impairment that often results in decreased capacity to understand instructions, process forms etc. as well as paranoid symptoms that interfere with simple tasks like opening up items in the mail and responding to written requests for information.

8. This is about money but we will be unable to meet the governor's expectation of $1.5 million in savings. Meanwhile, people will be hurt. People will suffer.

9. There are times when the drugs are not equal in view of other patient considerations such as comorbid conditions and remote drug trials. Also the cost of an hospitalization would far exceed any outpatient drug cost differential. That does not include the individual savings by being productive instead of out of work on a disability.

10. In psychiatry, different patients react differently to medications, and there is no way to predict what will work or be tolerated for a given person, although studies help us know what works in a population. Providing clinicians with information on costs of various medications would be useful, so that we can choose the lower cost options that are clinically appropriate. Limiting access to certain meds may not be clinically appropriate. If a patient has a history of failing multiple medications due to non-response or side effects, reasonable next steps are not necessarily the cheapest medication.

11. I think the idea of a preferred drug list is a rational and consistent way to mange the increasing cost of medications which is bankrupting Medicaid services, decreasing availability of care, and cost shifting away for institutions and providers who deliver the care.

12. I think this is long overdue.

13. OK.

14. Preferred Drug list should not include only drugs from the lowest bidding pharmaceutical company. It needs to be well thought out and include the medications with good efficacy and low side effect burden. It is critical to keep in mind the highly variable response achieved in

individual patients which differentiates these classes from many others. Overall I remain opposed to a PDL for the most severely ill psychiatric patients. What happened to narrowing the SPMI definition rather than taking this step????

15. A PDL should make allowances for special needs groups such as those with drug dependencies.

16. Reasonable as long as a certain degree of grandfathering is allowed.

17. Sounds reasonable unless the patient is already successfully on a medication, then gets on Medicaid and is told he/she needs to change. Bad idea. I would support this only with new starts. Fair enough?

18. Patient response to psychotropic medication is often unique and idiosyncratic. Unlike many other drugs classes that can be expected to produce similar results regardless of the choice of a particular drug, clinical psychiatry typically requires multiple drug trials for a particular patient to determine a suitable balance of clinical effect and tolerability. If the requirement that preferred drugs be tried first is compatible with the patient's history and general medical status, it is a reasonable idea.

19. I would not recommend switching anyone already on meds, but only prospectively.

Generic Trials - A focused generic approach would be applied with both generic alternatives and equivalents identified through the PDL. Generics would have to be trialed before a branded product could be selected.

Comments:

1. Generic drugs are not exactly the same as brand name drugs. As an RN for over 25 years, I have seen some patients respond poorly to generics, but do well on Brand name drugs. This applies to drugs that treat mental illness as well. If a patient has already responded well to a brand name drug, they should not be switched. If they are starting from scratch, a generic could be trialed first.

2. Who will be willing to sign up as those on whom these generics will be tested? How much faith can I have that their experience will be that of my own family members? Two other family members depend on prescribed medication in order to stay fully employed, and one had a severe reaction last winter while trying a new medication**.**

4. This seems reasonable**.**

5. When looked at with any degree of pharmacological sophistication, some medicines simply do not have generic equivalents. This is true of virtually all of the "second generation" or "atypical" antipsychotics, which are quite different pharmacological entities from older antipsychotics. The

fact that both groups of chemicals are called antipsychotics does make them "equivalents." Will you (OVHA) be approaching this with the appropriate degree of sophistication**?**

6. This is unacceptable for Behavioral Healthcare. It is a well known fact that newer atypical antipsychotics provide much better first-line symptom relief than medications that have been around long enough to have generic equivalents. Even the oldest atypical on the market, Clozaril has proven more efficacious than Clozapine (generics) due to bioequivalence problems. Often pharmacy practice is to purchase the "best deal" among several generic manufacturers, and switch generics as prices change. In the case of Clozapine the wide range of bioequivalence has resulted in one manufacturer's product providing a significantly different effective dose than another. In many cases anecdotal information following successful suicides has included information that the deceased had been switched from Clozaril to the generic Clozapine shortly prior to the suicide.

8. This is ok where generics or generic equivalents exist.

9. This is not clinically prudent if the drugs have minor but significant differences.

10. It is appropriate to require trial of a generic first, if available. USUALLY the generic and the branded version of the same drug work pretty comparably. I have seen only rare exceptions. I am not sure what you mean by equivalents; if it is a different chemical, it may not be equivalent in psychiatry.
Mode of delivery matters, too. I have seen patients be far more successful on a weekly medication (eg, Prozac Weekly) than daily medication.

11. I have extensive experience in switching individuals to generic alternatives to expensive agents (SSRIs and valproic acid). While there are individuals who cannot tolerate the generic alternative, the vast majority of patients in my experience can. Their medications cost a small fraction of what the non-generic alternatives would cost. Starting with a generically available agent, when there are not contraindications, should always be the default of the fiscally responsible prescriber.

12. Again, I think this is long overdue. While there are problems with haloperidol, for instance, in many instances the supposed safety over relative rare ADE's is simply not warranted.

13. OK.

14. Again, this would make sense for those outside of a more narrowed SPMI exempt class, recognizing that some pts will require brand name. Once it is established that a brand is required than a single PA should be required rather that a PA every number of months.

15. There are certain conditions in which generics simply do not work as well.

17. Agree except per above.

18. This is a reasonable requ8irement for those drugs available as generics.

19. There are some generics that are not as consistent – do you have a list and can you exempt (tegretol)?

Criteria for Behavioral Health Drugs for Behavioral Health Use – The PDL Clinical Criteria would include steps to assure that drugs are being prescribed for their designated use and not for off-label purposes; for example, as sleep aids, for managing aggression, etc.

Comments:

1. Given that so many meds to treat mental illness are not well understood (i.e.they don't know exactly how or why they work- but they do- so they are prescribed) , it would be wise to set in place a process to approve off-label use on a case by case basis.

2. There is a huge need to educate the doctors prescribing drugs since many get their information mostly from drug reps as new products come on the market (often at exorbitant prices). We have an excellent medical director locally, but she has many other responsibilities. Using the best available medications for their intended purposes, many clients still need to endure 15 to 20 trials over time before finding safe effective medication that suits their individual needs**.**

3. We finally have some agents available whose side effects are beneficial and because they are not FDA approved we can't use them? I think this puts too much of a restriction on Psychiatrists and other Mental Health Care Professional that prescribe.

4. I would be careful with this. There are many drugs with excellent clinical studies that for whatever reason the maker did not want to get FDA approval. It would be reasonable for exceptions in which clinical trials have demonstrated benefit and use is well accepted as standard of care.

5. If you can assure me that insomnia, aggression, etc. will never, ever again be a feature of mental illness, I could then assure you that I will never, ever again prescribe medications off-label for these purposes. If you can't live up to your end of this bargain, how can you expect me to live up to mine?

6. If this is to be the case there should be a means of prescribing off-label medications such as a waiver – for example, a patient may not be a candidate for a benzodiazapine due to addiction/substance abuse yet would benefit from an atypical antipsychotic or an SSRI to help control anxiety.

8. This proposal is a significant problem. It is a myth that FDA approves uses are the only bonafide uses. There will be an uproar if some pharmacist starts making up rules without significant input from practicing physicians.

9. Off label uses are often significant and may take years to become accepted. If the number of patients is not significant, the drug company may never pay for the testing to become "labeled".

10. Bad idea. Many medications have useful, and sometimes lifesaving, new uses which emerge from research or expert clinical experience. Medications may never get a particular FDA indication, because of financial factors, yet are very acceptable in clinical practice. It would be a tragedy to deprive patients and clinicians of those options. Trazodone as an insomnia and anxiety medicine is an example.

11. Again, through my work in the department of corrections, I see that the community standard has spiraled to very concerning level. In the hopes of minimizing the alcohol or drug dependent patient becoming benzodiazepine dependent, more and more individuals are being prescribed very expensive atypical antipsychotics whose side effects are not subtle. Quetiapine is frequently used as a sleep aid or in small doses for anxiety. Most often, I do not see that these individuals are in comprehensive treatment for their substance use or other psychiatric disorders. The availability of psychiatric consultation is a problem, but it appears that many psychiatrists have begun to adopt this community standard as well.

12. Off label use doesn't necessarily imply inappropriate use. However, if a cheaper substitute will work for the same off label use, I think it should be tried.

13. Disagree. Should be up to discretion of physician prescribing.

14. This is very concerning as a number of well established treatment strategies have not been FDA approved. FDA approval often lags behind. I would be very concerned about having to explain an off label use to a pharm tech on the phone. I would disagree with this criteria and am not familiar with its use in other medical specialties.

15. In special groups, the off label aspect of these meds are very important.

16. Off-Label use should be fair game especially for specialists.

17. Totally and strongly disagree. As a Dr who does a lot of psychopharm, I know that there are very few studies and that the FDA approval process has more to do with marketing than patient care. Ask any psychiatrist what the standard is in the psych community. Med use is _____, often 'off label', and often very successful (i.e., this proposal goes against the current standard of care).

18. Off label uses are often very appropriate and cost effective, so a blanket prohibition is not appropriate. For example, trazadone is often used to offset the insomnia caused by SSRI's. Drugstore.com lists a thirty day supply at $7.99. On the other hand, eszopiclone (Lunesta), now with a clear indication for long-term treatment of insomnia, would cost $98.99 for the same time period.

19. Hmm …. What will you do with all the kids who the psychiatrist is treating with Nerontin and atypical anti-psychotics. I have very mixed feelings about this issue, but it's complicated.

Prior Authorization- This would be required to access a medication which is non-preferred. A prescriber would have to request an authorization for coverage of a non-preferred drug

demonstrating that preferred drugs had been trialed and requirements for documentation of the clinical reasons for the need of the non-preferred medication have been met.

Comments:

1. As long as this process is not lengthy and so bureaucratic as to prevent consumers and families from actually utilizing it**.**

2. As I read this you must demonstrate that a consumer has become ill when using the generic in order to allow them to return to the currently used effective medication, unless it is on the new preferred list. This seems a script for disaster, since we have the least amount of resources available for hospitalization of any time since my son became ill in the 1980's.

3. Adds more tasks to an already over burdened system**.**

4. Seems reasonable; I would say the use of bup in pregnancy (verses methadone) fits this category.

5. OK, but realize that this is not a cost-free option. It costs. It costs the physician time, which disables him/her from treating other patients. Given the dearth of access to psychiatric care to begin with, this means that more patients will not receive adequate routine treatment, which means that more patients will present in acute crises and more patients will require far more expensive, comprehensive treatment that could have been avoided. If that sounds good to you, so be it. It doesn't to me. In most instances, prior authorization requests could be reasonably handled with a two-minute phone call (assuming that you or your contractor have provided for enough "operators standing by" to answer all calls within a minute). Please make that happen**.**

6. This is unacceptable for persons with SMI – often they have functional deficits that are so debilitating that it is both poor practice and inhumane treatment to go through trials on non-preferred drugs. The longer it takes to abate symptoms, to poorer are long-term outcomes. This is not only poor medicine, it is unethical.

8. This could be bearable or unbearable depending on how it is implemented, and what "documentation of the clinical reasons" turns out to be.

9. This process needs to be fast and timely. 24 hour telephone response time would be ideal. A control number could then be given which the pharmacy would use in billing.

10. Vermont is very short on psychiatrists. Patients are having a terrible time getting access. Giving psychiatrists busywork to do so the patient can access a medication only makes us able to serve fewer people and wastes time. What would be very helpful is a thorough 'academic detailing' type of **review course to update us on the most current research and practice, and on costs of medications**, free of drug company influence. This would be presented in several locations, by expert psychiatrists, and all VT psychiatrists would be asked to attend one (for CME credit, of course.) **Sometimes there are very appropriate reasons to pick a more expensive drug right off the bat, and it is not in the patient's best interest to go through**

multiple drug trials. Patients may become non-compliant, discouraged, or drop out of treatment when medications do not work or seem to cause undesirable side effects. The treatment alliance can be very fragile, with patients who are reluctant to begin with.

11. While this is inconvenient at times, it keeps us all from defaulting to what allows us to come up with a quick solution that shortens appointment times. More and more frequently patients are asking for specific medications which are being marketed to them.

12. I agree.

13. OK.

14. As above.

15. As long as there is a doctor, preferably a psychiatrist, available for a clinical discussion.

16. If final determination rests with the prescribing doctor, okay.

17. OK but not the way it is currently done. Rigid automatons is not what we need. A clinical feeling reasonable person, OK. But w/o it's harassment.

18. The requirements for pre-authorization creates huge burden for physicians treating these patients. While previous problems with telephone access to authorizing personnel have improved, the time needed to compile and relay the clinical history and find answers in the record to specific questions is considerable. In addition, the clinician who does not segregate Medicaid patients cannot easily track which people need authorization for which drugs. The patient often arrives at the pharmacy, only to be sent away while the physician is notified and finds the time to call for authorization. I would recommend clear guidelines, physician education, and perhaps a scheduled retroactive review for physicians whose prescribing profile suggests lack of knowledge about the guidelines. It is critical to consider the burden to physicians as the number of psychiatrist available for clinical service in Vermont becomes more problematic.

19. Only proactively, not retroactively.

Expedited Prior Authorization – Specified patients with specified conditions would be identified to expedite prior authorization.

Comments:

1. A clear definition of what specified patients and conditions would be considered for this category would be necessary to allow comments by the public**.**

2. I have no idea what this means. My son has schizoaffective disorder; my grandson pediatric onset of bipolar disorder as far as we can tell at this time. What criteria would identify you as desperate enough that no one should experiment with the possibility of triggering another onset of severe psychosis or suicide? My son lives independently but is unable to work. I only see

him once each week. My grandson was on 24-hour watch last winter for months before and after his time at the Baird Center.

3. This would be helpful**.**

4. It seems most behavioral drugs may need this.

5. This could all be expedited in a reasonable prior authorization process.

8. Just how do you propose to do this?

9. Same as above. 'This process needs to be fast and timely. 24 hour telephone response time would be ideal. A control number could then be given which the pharmacy would use in billing.'

10. Why do prior authorization? See above. **If we must have prior authorization, a fast phone call with no waiting is essential. Many of us have no staff to do these things.**

11. Of course there should be exceptions made to the general formulary. There are reasons not to disrupt or change certain therapies with certain patients depending on history of other treatments and risk of change of treatment.

12. I agree.

13. OK.

14. Again, this group should be continued in an exempt class.

15. Absolutely.

16. Should include patients recently discharged from the hospital.

17. I like it!

18. Any process that improves efficiency and saves time is most welcome.

19. They all need to be expedited.

Claims Applied Step Therapy Edits – Specified non-preferred drugs could be accessed by the patient when his/her claims' history indicated a trial of a preferred product or a trial of another product that would represent the first line treatment of the condition. In this way the prescriber would not have to formally require a Prior Authorization because the claims' history would demonstrate that the required steps had been taken.

Comments:

1. If this means that one would not have to do multiple trials to prove the non-success of "preferred drugs" I agree.

2. This is a relief to read, but how many of these will be allowed?

3. This maybe extremely helpful especially if the client has accessed two or three different practitioners.

4. Reasonable.

5. Of course.

6. This is only helpful in a case where there is a claims' history. With SMI, first-line prescribing practice should not have the need for any prior authorization.

8. This could be nice, but how would we ever know which patient qualifies, except by making the call to First Health, which we would have to do in any case to obtain prior authorization?

9. Good idea but it has to be clinician friendly – long forms unacceptable.

10. It might be appropriate to do this for certain medications, but only if it is consistent with current, optimal practice.

11. See above. 'Of course there should be exceptions made to the general formulary. There are reasons not to disrupt or change certain therapies with certain patients depending on history of other treatments and risk of change of treatment.'

12. I'm not sure I understand this.

13. OK.

14. What would constitute first line? The least expensive drug?? Am not clear how this would be determined. By an algorithm and if so which one? This is even more constraining on prescribing practices than a PDL.

15. Fine.

16. Reasonable.

17. Excellent - unless that person has had an interruption in their coverage and you do not have all the records. Only you (OVHA) know exactly how common that is.

18. If this can be determined from internal records, it would again reduce the burden on physicians. I suspect that relatively few patients will have adequate and accessible data base.

19. Claritan is often used OTC and wouldn't _____ up, we often get challenged about this.

Non-Preferred Drug Trials – Specified non-preferred products would be limited to a trial period authorization on initial use to determine if they produced the desired clinical results.

Comments:

1. This needs to be at least 2 months. Therapeutic outcomes are not often even beginning to be evident for 4 weeks.

2. This appears to be what any good Psychiatrist prescribing should be doing as follow-up with their patient who is beginning any new medication.

4. As long as the trial is of reasonable length (at least 8 weeks) and not too much paperwork needs to be repeated to continue the drug.

5. Fine, as long as that limited period is no less than three months.

8. Do you truly believe that we would continue to prescribe a medication that did NOT produce the desired clinical results? All this appears to do is to require a second phone call at some predetermined interval after the first phone call. A better way would be to allow the use of a non-preferred drug for a specified period of time BEFORE requiring authorization. This would save us a few phone calls. HOWEVER, it will probably be rejected, since First Health is paid for each phone call we have to make.

9. Has to be drug dependent – some drugs such as Elavil require long clinical trials before declared ineffective.

10. I don't think any of us are going to stay with something if it is not producing a reasonable result. Perhaps, for the most expensive drugs, the prescriber could receive a reminder three months after the first prescription, suggesting less expensive options and asking whether they have been considered.

11. Excellent idea. Too often medications which are ineffective are not discontinued in the patients I am seeing. More medications are then added on to "augment" a medication which does not appear to have made a significant difference in the patient's clinical course.

12. I suspect that this isn't really going to achieve your goals. We know the atypical anti-psychotics work. They don't necessarily work better than older ones either. The main benefit is supposed avoidance of ADE's associated with use of the older medications. In many instances, this "benefit" isn't really needed.

13. OK.

14. Whole heartedly disagree here. If the prescriber has decided to go to the trouble to obtain a PA for a non-preferred drug then the authorization should be in place and not time constrained.

15. For special groups this should not be a requirement.

16. Recently hospitalized patients should be exempt from this.

17. Good. Agreed.

18. Again good idea in principle, but the burden of tracking the trial and reporting the result will fall on the physician, who rarely will have information systems available to flag this need.

Clinical Detailing- Clinical or operational trends in prescribing and dispensing practices would be identified for provider education utilizing drug utilization review data. This would help to identify issues of polypharmacy and/or off-label use after the fact.

Comments:

2. My understanding is that the drug companies are now able to access exactly which doctors are prescribing their new medications, and to what degree. Measuring the trends will be important to cost saving, but should be balanced with a measure of increased illness during and following these changes in medication.

4. Be careful of this approach; people develop certain types of pts which bring more of the same and can skew a profile.

5. That would be great so long as the level of feedback being provided is high caliber and sophisticated. It is a waste of everyone's time to have someone with less training and education than the prescriber contacting physicians whose names turned up by means of some standardized computer search and presenting them with boilerplate party lines about polypharmacy and off-label use. Polypharmacy and off-label use represent good care in some instances and bad care in others; please have a sufficiently sophisticated process to differentiate between the good and the bad before you start detailing physicians.

6. This may be beneficial as a tickler for identifying individual practice habits. It should not be used in any punitive manner.

8. THIS IS IMPORTANT, USEFUL, AND COST-EFFECTIVE if properly done, BUT: [1] very often a patient requires more than one medication, just as in the case of hypertension or COPD. [2] Off label use is important in many instances. Please be careful here and obtain input from practicing physicians – not just academicians and pharmacists.

10. While we would all prefer to avoid it, polypharmacy seems to be necessary for many treatment-resistant conditions, and also for many psychiatric conditions under current optimal clinical practice. Provider education is a great idea. However, justifying many patients' regimens after the fact is likely to be a waste of time and frustrating for clinicians.

11. I would welcome feedback on my practice patterns and seeing how it compares to my colleagues and national standards.

12. I agree with this, especially if all prescribers are included.

13. OK.

14. I would prefer this to a PDL and the lifting of a SPMI exemption. Isn't this what the legislature was recommending? Implementing a program such as that in Missouri? Why are we proposing this and so much more???

15. Good idea. Should be required for medical residents.

17. Good.

18. I think that monitoring trends is very reasonable, since it will be desirable to direct information to physicians whose prescribing is problematic. Again, I would note that off label use is not necessarily inappropriate. Polypharmacy of bipolar disorder is considered by many experts to be quite reasonable in difficult to treat patients. Reviews of aggregate data will require very sophisticated interpretation.

19. Who pays for M.D. time?

Patient Look Back- Patient specific claims' history would be reviewed to see if a certain drug or drug class has been dispensed in the past, or for a length of time in the past; to consider that use in conjunction with other drug use, and to determine the reasons for use and assess the appropriateness of the utilization. This may help to identify issues of polypharmacy and/or off-label use. Areas of concern would be targeted for intervention.

Comments:

1. Keep in mind that a clear history may not be readily available. As a nurse, I know that MD's and other providers of health care, rarely have a comprehensive medical history on patients with multiple providers. This could be compounded with mental health patients who may or may not be the best reporters of their own history.

2. I am wondering about the background of those who will be reviewing this since it appears to be driven by cost more than concern for the patients' welfare. How are you able to measure this from a chart or computer analysis?

3. What's the cost /benefit analysis?

4. Again, be careful of overstating the issue of off label use. Given the number of providers these pts see, this is reasonable in an ongoing manner (too many active scripts for a certain problem) but is on a pretty slippery slope as it will be difficult to understand what is pt verses provider driven.

5. See my previous response. It all depends on the quality and sophistication of the reviewer.

6. This may be beneficial as a tickler for identifying individual practice habits. It should not be used in any punitive manner.

8. Useful.

9. For some illnesses you need lifelong records.

10. I have no idea what this run-on sentence question means. Please explain. Not sure how this differs from the previous question. See comments above.

11. Enormously helpful. Patients with psycho-social challenges are frequently poor historians and have seen multiple providers in multiple systems. Having available reliable data from past treatments would be an excellent use of that data and should improve treatment and efficiency of time to effective treatment.

12. I don't think this is needed. I would still prefer a trial of the older meds first.

13. OK.

14. As above.

17. OK but per above concerns.

19. Again, who would pay for M.D. time?

Best Clinical Practice Review – Patterns of use would be compared to standards of care determined by medical specialty practice groups or professional organizations which offer guidelines for treatment of selected diseases based on true medical necessity. Variances would be targeted for intervention.

Comments:

1. As I said before, if you have a successful therapy it would be "Pennywise and pound foolish" to monkey with it to save medication dollars only to end up with relapses and hospitalizations that would far exceed the cost of "non-preferred" drugs**.**

2. Best practice reviews may assist doctors who are not well informed. What kind of intervention do you have in mind? More education or simply refusing to pay for what seems too expensive? Is the practice going to be guided by maximum well-being or minimal cost?

4. Very difficult without full chart review of each patient's chart and the rationale of treatment plan**.**

5. Don't target all variances for intervention; use some sophistication to determine which situations require intervention and which ones don't. You use the term "Behavioral Health." You

would have a much more appropriate comprehension of the issues if you used the term "Brain Diseases." We're
talking about the human brain here! The Brain is by far the most complicated of any human organ, at least1000 times more complex than any other human organ. The number of cells and synapses involved and the number of chemicals involved are vastly greater than any other organ system. The normal operation of human hearts, human kidneys, human lungs, etc. is virtually identical from one human being to the next. By contrast, no two human brains are identical. We are all variances!! No two humans have identical thoughts, identical feelings, identical personalities or identical behavioral responses in all situations at all times. The uniqueness of the human brain needs to be respected. This is one of the pitfalls of approaching psychopharmocology with the same paradigm being used for the pharmacotherapy in other areas of medicine: it fails to take into account the reality that the complexity and uniqueness of the human brain is so much more vast.

8. Good in general. But WHICH standards, developed by WHOM?

9. Not always available.

10. My understanding is that most clinical practice guidelines allow a good bit of flexibility on the part of the prescriber. Of course, they are the best starting points, but patients are individuals. Treatment has to be individualized, if standard treatment is ineffective or multiple conditions coexist.

11. Again, I would welcome any feedback about my practice pattern to improve my practice and outcomes.

12. I disagree.

13. OK.

14. As above.

17. OK. But be careful who you consult. The FDA is not a clinical guideline group. Many nurses know little about outpatient psychopharm or empiric med trials for neuropathic pain assoc'd with chronic fatigue.

18. Again, comparison of aggregate data requires that the compared populations be determined to be similar in relevant characteristics, and that valid statistical methods be used to determine variance. Also note that practice guidelines in psychiatry are often vague because of the immense variation in individual patient response and the common comorbidity of psychiatric conditions.

Other Ideas:

1. It is important to try save money and to achieve good outcomes. But it must be remembered that medications are the cheapest way to achieve good outcomes and it would be foolish to throw away success in the quest for lower cost. I am the Executive Director of a Visiting Nurse

Association and advocate for our patients with insurance companies as part of my job. Applying these skills to my daughter's situation in 2001, I succeeded in getting MVP to pay for a post-hospitalization rehab stay at XXXXXXX in XXXXX for my daughter for 2 months, by explaining to them that I did not want her to have a relapse and at cost of $16,500/monthly at the XXXXX, **neither should they**. They paid for her $4,500/month stay there and she has been improving ever since. Good outcomes may be expensive, but they are MUCH cheaper than bad ones.

2. The categories seem perfectly rational, but the overall idea is chilling to a mother and grandmother trying to manage the needs of a large family. I served on the State Program Standing Committee, and continue since 1997 on the local standing committee for adult MH services at the Howard Center.

3. Some general education provided by (OVHA) with CME available on current medications and generic equivalents may be more constructive for the Mental Health Care providers. Particularly the Nurse Practitioners and Physician Assistants who are prescribing.] With the shortage of Psychiatrists more and more Primary Care Providers are prescribing psychotropic medication and are more comfortable with newer safer agents that are available. I feel that restricting Psychiatrists and other Prescribers in the Mental Health arena is only cost shifting and a disaster waiting to happen. With the State Hospital closing and fewer and fewer psychiatrists patients who are destabilized because of medication changes will be demanding more services from out Crisis Teams and Case Managers along with the private Psych units available. With an already overburdened system we need to think carefully about some of these guidelines. How much will we really save if the cost shift is taken up by our Community Mental Health Centers. ?

4. The greatest challenge to this approach is that there is not uniform distribution among practices regarding the type of pt- individuals develop specific types of pts. A better approach might be to identify a few practitioners and follow-up with detailed chart review and see if these approaches can be validated. Then you may be able to get buy in from the practitioners.

7. I am an FP "in the trenches" The situation is often that I am doing psychiatry. I wonder if the expansion of the rules governing these meds might allow for a quick consult with a psychiatry group or an identified resource to discuss alternatives. For example, someone goes to the Retreat or Conifer. They get discharged on Seroquel (common practice) They come to see me. No records. I know they are not schizophrenic or psychotic. I am then scratching my head saying what to do as this is not an acceptable drug choice but I have no diagnosis. With some guidance, I might have a shot. It will take months for them to access psychiatry, if at all, especially with Medicaid, so it is really up to me. If the discharging hospitals also had a list of meds that they were restricted to that would help as they would only use those that are covered.

8. [1] Identify which medications can be given once a day [2] Identify which tablets can be split for more cost-effective prescribing. [3] Disseminate this information widely [4] REPEATED distribution of information on relative pricing of medications. [5] "Dear Doctor" letters re: prescribing patterns and practices – but have these letters reviewed by practicing physicians first!

10. Allow Medicaid/VHAP patients a "trial" small prescription, with no copay (eg, one week of a drug new to them.) This would allow them to try a medication new to them without paying a copay, and then paying again after we decide they can tolerate the drug and giving them a one-month supply. This would help us avoid wasting medication by writing for more just because the patient wants to avoid another copay. It would be very helpful for commercial insurers to allow this, as well. I recently ran into it on a Blue Shield patient who didn't want to pay two $15 copays in one month. I, on the other hand, don't like writing an initial prescription for a month's worth of medication, because we often wind up throwing it out if the patient cannot tolerate it. It is a waste of money and medication.

12. Let's create mandatory electronic prescribing in Vermont with 2 requirements in addition to the usual prescription requirements: a. A diagnosis or diagnoses to go with each prescription; b. A list of all allergies.

14. I suspect the bottom line is wanting to get the pharmacy companies to the table to negotiate a price break. This is ok for the non exempt population, but is very concerning for the more seriously ill especially with respect to the antipsychotics. Say Zyprexa was considered a first line agent because Lilly agreed to a very low price. Then all the young new clients with schizophrenia get put on this first. This would be bad medicine. PCP's with less familiarity will do just this. I remain confused as to why we have moved away from a detailing and educational plan to a plan to lift the entire exemption. When and how did this happen???

End of responses.

Report
Health Access Oversight Committee
Pharmacy Benefit Management Program
Behavioral Health Drug Proposal
September 1, 2005
Attachment G
Data Analysis Project Description

Vermont Health Access
Pharmacy Benefit Management Program

Data Analysis Project for the Utilization of Drugs Used to Treat Severe and Persistent Mental Illness

The August 8, 2005 analysis is based on eligibility, medical claims data and prescription claims data from January 1, 2002 through May 31, 2005. The data set includes a current snapshot of the data from January 1, 2005 through May 31, 2005.

This analysis established a baseline for eligibles who were defined as exempt from any Preferred Drug List restrictions for drugs used to treat severe and persistent mental illness (SPMI). As currently applied, the qualification was granted without an end date once an individual qualified for an exemption. In establishing the drug cost of these patients, the patient was flagged at the onset of the exemption and their claims were added to the cost of the exemption category for the data set's time period.

The following is the exemption criteria for SPMI:

- Patient is diagnosed with schizophrenia or bipolar disorder.
- Patient is diagnosed with an ICD 9 behavioral health or substance abuse diagnosis (including major depression) (290.00 - 319.00) **and** has or has had a history of impairment due to the behavioral illness that affects his/her ability to function such that the patient is suicidal, has no friends, neglects family, is unable to work or keep a job, is withdrawn to home or room, stays in bed all day, becomes violent or has even lesser degrees of functioning (Global Assessment of Functioning Scale score of 50 or less)
- Patient is a past or current user of traditional or atypical antipsychotic medication.
- Patient has received chronic therapy with any antidepressant medication (received at least 300 days supply of medication during a 365 day period).
- Patient has received chronic therapy with any central nervous system stimulant medication (received at least 240 days supply of medication during a 365 day period).
- Presence of a CRT code in eligibility file.
- Patients are less than 18 years of age.

Data Reports' Keys

Antidepressant – exemption includes antidepressant medication

Antidepressant only - exemption is by antidepressant medication only

Antipsychotic – exemption includes antipsychotic medication

Severe and Persistently Mentally Ill Data Analysis Project

Antipsychotic, CRT, or BHD (Behavioral Health Diagnosis) - eligible meeting one or more of these criteria

Antipsychotic only – exemption is by antipsychotic medication only

Bipolar – exemption by ICD-9 codes 296.4-296.7

Bipolar only – exemption by ICD-9 codes only

BHD (Behavioral Health Diagnosis) – ICD-9 codes 290 - 319

BHD only – exemption by ICD-9 code only

BH drug – behavioral health drug

CRT – VDH/OVHA identifier code

CRT only – exemption by CRT code only

Exemptable BH drug – behavior health drug, the use of which exempts the patient

HIC3 – First Data Bank Therapeutic Class codes

Juv(nn) – juvenile eligible under the age of eighteen as of January first of year (nn)

Non-exemptable BH drug – behavior health drug, the use of which does not exempt the patient

No SPMI exemption – summary for those with no exemption criteria

Overall – summary on exemption criteria

Schizophrenia – ICD-9 codes 295.0 – 295.9 and 299.9

Schizophrenia only – exemption by ICD-9 codes only

SPMI exempt: all excluding BHD only – SPMI exempt based on exempting conditions other than BHD only

Stimulant – exemption includes CNS stimulant medication

Stimulant only – exemption is by CNS stimulant medication only

Stimulant or antidepressant – eligible meeting one or both of these criteria

Total: BHD only, SPMI Exempt, no BHD or SPMI exemption – summary for everyone in managed programs

Report
Health Access Oversight Committee
Pharmacy Benefit Management Program
Behavioral Health Drug Proposal
September 1, 2005
Attachment H
Expenditure and Utilization Data

All eligibles exempt by the current Severe and Persistent Mental Illness Definition from January 2002 through May 2005

		Stimulant	Antipsychotic	Juv02	Juv03	Juv04	Juv05
1	Number of Patients	4692	13603	74181	71465	68454	65385
	% of total population	2.42%	7.02%	38.30%	36.90%	35.34%	33.76%
2	Total Drug Cost	31,534,260.37	153,638,739.33	68,231,763.26	65,574,213.27	62,237,351.93	58,085,329.42
	% of Total Drug Cost	6.28%	30.57%	13.58%	13.05%	12.38%	11.56%
	Drug Cost Per Patient	6,720.86	11,294.47	919.80	917.57	909.19	888.36
3	Non-BH Drug Cost	8,865,952.07	56,322,607.77	41,038,904.04	39,587,211.60	37,669,398.21	35,425,299.93
	% of Non-BH Drug Cost	2.60%	16.53%	12.05%	11.62%	11.06%	10.40%
	Non-BH Drug Cost Per Patient	1,889.59	4,140.45	553.23	553.94	550.29	541.80
4	Antipsychotic Drug Cost	5,692,153.93	56,855,397.41	7,636,088.89	7,234,938.89	6,882,358.59	6,285,417.11
	% of Antipsychotic Drug Cost	10.01%	100.00%	13.43%	12.73%	12.11%	11.06%
	Antipsychotic Drug Cost Per Patient	1,213.16	4,179.62	102.94	101.24	100.54	96.13
5	Antidepressant Drug Cost	3,716,190.65	17,695,797.92	5,477,626.61	5,129,980.42	4,680,887.97	4,062,901.87
	% of Antidepressant Drug Cost	7.61%	36.24%	11.22%	10.50%	9.59%	8.32%
	Antidepressant Drug Cost Per Patient	792.03	1,300.87	73.84	71.78	68.38	62.14
6	Stimulant Drug Cost	10,655,632.62	4,134,751.35	9,655,772.46	9,534,923.10	9,329,053.49	8,941,941.79
	% of Stimulant Drug Cost	87.51%	33.96%	79.30%	78.31%	76.62%	73.44%
	Stimulant Drug Cost Per Patient	2,271.02	303.96	130.17	133.42	136.28	136.76
7	Total Exemptable BH Drug Cost	20,063,977.20	78,685,946.68	22,769,487.96	21,899,842.41	20,892,300.05	19,290,260.77
	% Total Exemptable BH Drug Cost	17.02%	66.76%	19.32%	18.58%	17.73%	16.37%
	Total Exemptable BH Drug Cost Per Patient	4,276.21	5,784.46	306.95	306.44	305.20	295.03
8	Anxiety and Sedative Hypnotic Drug Cost	351,964.73	3,103,331.63	163,409.14	137,791.59	114,249.21	94,744.10
	% of Anxiety and Sedative Hypnotic Drug Cost	4.27%	37.63%	1.98%	1.67%	1.39%	1.15%
	Anxiety and Sedative Hypnotic Drug Cost Per Patient	75.01	228.14	2.20	1.93	1.67	1.45
9	Mania Drug Cost	53,235.38	431,026.57	102,351.01	94,861.81	89,312.32	77,462.00
	% of Mania Drug Cost	10.10%	81.76%	19.41%	17.99%	16.94%	14.69%
	Mania Drug Cost Per Patient	11.35	31.69	1.38	1.33	1.30	1.18
10	Anticonvulsant Drug Cost	2,199,130.99	15,095,826.68	4,157,611.11	3,854,505.86	3,472,092.14	3,197,562.62
	% of Anticonvulsant Drug Cost	6.24%	42.81%	11.79%	10.93%	9.85%	9.07%
	Anticonvulsant Drug Cost Per Patient	468.70	1,109.74	56.05	53.94	50.72	48.90
11	Total Non-Exemptable BH Drug Cost	2,604,331.10	18,630,184.88	4,423,371.26	4,087,159.26	3,675,653.67	3,369,768.72
	% Non-Exemptable BH Drug Cost	5.91%	42.31%	10.05%	9.28%	8.35%	7.65%
	Total Non-Exemptable BH Drug Cost Per Patient	555.06	1,369.56	59.63	57.19	53.70	51.54
12	Total BH Drug Cost	22,668,308.30	97,316,131.56	27,192,859.22	25,987,001.67	24,567,953.72	22,660,029.49
	% Total BH Drug Cost	14.00%	60.11%	16.80%	16.05%	15.17%	14.00%
	Total BH Drug Cost Per Patient	4,831.27	7,154.02	366.57	363.63	358.90	346.56

Antidepressant	CRT	BHD	Schizophrenia	Bipolar	Antipsychotic, CRT, or BHD	Stimulant or Antidepressant	Stimulant Only	Antipsychotic Only
20181 10.42% 1,706.03	3318 1.71% 16,787.58	70660 36.48% 3,900.07	844 0.44% 18,391.88	1508 0.78% 8,341.55	73246 37.82% 4,069.76	23373 12.07% 10,335.02	71 0.04% 7,390.52	1467 0.76% 5,615.97
228,167,053.42 45.40% 11,306.03	55,701,176.58 11.08% 16,787.58	275,578,922.83 54.84% 3,900.07	15,522,749.20 3.09% 18,391.88	12,579,060.33 2.50% 8,341.55	298,093,969.85 59.32% 4,069.76	241,560,478.44 48.07% 10,335.02	524,726.83 0.10% 7,390.52	8,238,633.81 1.64% 5,615.97
127,405,219.69 37.40% 6,313.13	15,523,837.24 4.56% 4,678.67	145,254,066.50 42.64% 2,055.68	3,704,053.64 1.09% 4,388.69	3,990,951.96 1.17% 2,646.52	157,728,336.07 46.30% 2,153.41	130,801,263.15 38.40% 5,596.25	379,357.95 0.11% 5,343.07	5,012,192.09 1.47% 3,416.63
32,582,126.21 57.31% 1,614.50	26,673,774.28 46.92% 8,039.11	51,051,057.40 89.79% 722.49	9,379,004.10 16.50% 11,112.56	3,994,403.54 7.03% 2,648.81	56,855,397.41 100.00% 776.23	34,788,164.08 61.19% 1,488.39	0.00 0.00% 0.00	2,356,531.33 4.14% 1,606.36
40,691,662.67 83.33% 2,016.34	5,626,386.77 11.52% 1,695.72	35,666,014.73 73.03% 504.76	936,663.78 1.92% 1,109.79	1,374,651.51 2.81% 911.57	37,988,238.64 77.79% 518.64	41,043,529.29 84.05% 1,756.02	10,815.85 0.02% 152.34	201,697.98 0.41% 137.49
4,439,677.80 36.46% 219.99	444,998.92 3.65% 134.12	11,502,587.97 94.47% 162.79	54,697.58 0.45% 64.81	447,173.93 3.67% 296.53	11,582,736.13 95.12% 158.13	10,946,336.02 89.90% 468.33	120,533.04 0.99% 1,697.65	7,700.65 0.06% 5.25
77,713,466.68 65.93% 3,850.82	32,745,159.97 27.78% 9,868.95	98,219,660.10 83.33% 1,390.03	10,370,365.46 8.80% 12,287.16	5,816,228.98 4.93% 3,856.92	106,426,372.18 90.29% 1,453.00	86,778,029.39 73.62% 3,712.75	131,348.89 0.11% 1,849.98	2,565,929.96 2.18% 1,749.10
4,813,828.08 58.37% 238.53	1,176,568.87 14.27% 354.60	5,112,928.28 62.00% 72.36	201,166.13 2.44% 238.35	254,148.38 3.08% 168.53	5,599,532.29 67.90% 76.45	4,900,583.67 59.42% 209.67	6,246.04 0.08% 87.97	147,491.21 1.79% 100.54
252,185.88 47.84% 12.50	218,975.46 41.54% 66.00	479,778.29 91.01% 6.79	36,686.92 6.96% 43.47	148,212.23 28.11% 98.28	511,334.22 96.99% 6.98	281,169.17 53.33% 12.03	0.00 0.00% 0.00	15,807.63 3.00% 10.78
17,982,353.09 51.00% 891.05	6,036,635.04 17.12% 1,819.36	26,512,489.66 75.19% 375.21	1,210,477.05 3.43% 1,434.21	2,369,518.78 6.72% 1,571.30	27,828,395.09 78.92% 379.93	18,799,433.06 53.32% 804.32	7,773.95 0.02% 109.49	497,212.92 1.41% 338.93
23,048,367.05 52.34% 1,142.08	7,432,179.37 16.88% 2,239.96	32,105,196.23 72.91% 454.36	1,448,330.10 3.29% 1,716.03	2,771,879.39 6.29% 1,838.12	33,939,261.60 77.08% 463.36	23,981,185.90 54.46% 1,026.02	14,019.99 0.03% 197.46	660,511.76 1.50% 450.25
100,761,833.73 62.24% 4,992.91	40,177,339.34 24.82% 12,108.90	130,324,856.33 80.50% 1,844.39	11,818,695.56 7.30% 14,003.19	8,588,108.37 5.30% 5,695.03	140,365,633.78 86.70% 1,916.36	110,759,215.29 68.41% 4,738.77	145,368.88 0.09% 2,047.45	3,226,441.72 1.99% 2,199.35

Antidepressant Only	CRT Only	BHD Only	Schizophrenia Only	Bipolar Only	All Including BHD	SPMI Exempt: All Excluding BHD Only	No BHD or SPMI Exemption	Total: BHD Only, SPMI Exempt, No BHD or SPMI Exemption
5516 2.85% 58,019,368.95 11.55% 10,518.38	9 0.00% 6,463.56 0.00% 718.17	27521 14.21% 48,362,134.69 9.62% 1,757.28	0 0.00% 0.00 0.00% N/A	0 0.00% 0.00 0.00% N/A	79070 40.82% 358,366,723.29 71.31% 4,532.27	51549 26.61% 310,004,588.60 61.69% 6,013.78	114617 59.18% 144,171,209.84 28.69% 1,257.85	193687 100.00% 502,537,933.13 100.00% 2,594.59
45,880,972.64 13.47% 8,317.80	1,061.02 0.00% 117.89	39,387,210.48 11.56% 1,431.17	0.00 0.00% N/A	0.00 0.00% N/A	205,071,044.46 60.20% 2,593.54	165,683,833.98 48.64% 3,214.10	135,567,245.76 39.80% 1,182.78	340,638,290.22 100.00% 1,758.70
0.00 0.00% 0.00	0.00 0.00% 0.00	0.00 0.00% 0.00	0.00 0.00% N/A	0.00 0.00% N/A	56,855,397.41 100.00% 719.05	56,855,397.41 100.00% 1,102.94	0.00 0.00% 0.00	56,855,397.41 100.00% 293.54
8,627,419.65 17.67% 1,564.07	1,751.48 0.00% 194.61	3,300,394.75 6.76% 119.92	0.00 0.00% N/A	0.00 0.00% N/A	46,835,848.96 95.91% 592.33	43,535,454.21 89.15% 844.55	1,998,390.50 4.09% 17.44	48,834,239.46 100.00% 252.13
19,925.30 0.16% 3.61	0.00 0.00% 0.00	124,336.89 1.02% 4.52	0.00 0.00% N/A	0.00 0.00% N/A	12,039,274.89 98.87% 152.26	11,914,938.00 97.85% 231.14	137,175.26 1.13% 1.20	12,176,450.15 100.00% 62.87
8,647,344.95 7.34% 1,567.68	1,751.48 0.00% 194.61	3,424,731.64 2.91% 124.44	0.00 0.00% N/A	0.00 0.00% N/A	115,730,521.26 98.19% 1,463.65	112,305,789.62 95.28% 2,178.62	2,135,565.76 1.81% 18.63	117,866,087.02 100.00% 608.54
1,091,566.94 13.24% 197.89	0.00 0.00% 0.00	931,131.84 11.29% 33.83	0.00 0.00% N/A	0.00 0.00% N/A	6,720,837.44 81.50% 85.00	5,789,705.60 70.21% 112.31	1,525,966.69 18.50% 13.31	8,246,804.13 100.00% 42.58
5,127.00 0.97% 0.93	69.26 0.01% 7.70	16,626.84 3.15% 0.60	0.00 0.00% N/A	0.00 0.00% N/A	517,332.00 98.13% 6.54	500,705.16 94.98% 9.71	9,860.28 1.87% 0.09	527,192.28 100.00% 2.72
2,394,357.42 6.79% 434.07	3,581.80 0.01% 397.98	4,602,433.89 13.05% 167.23	0.00 0.00% N/A	0.00 0.00% N/A	30,326,988.03 86.01% 383.55	25,724,554.14 72.96% 499.03	4,932,571.45 13.99% 43.04	35,259,559.48 100.00% 182.04
3,491,051.36 7.93% 632.90	3,651.06 0.01% 405.67	5,550,192.57 12.60% 201.67	0.00 0.00% N/A	0.00 0.00% N/A	37,565,157.47 85.31% 475.09	32,014,964.90 72.71% 621.06	6,468,398.42 14.69% 56.43	44,033,555.89 100.00% 227.34
12,138,396.31 7.50% 2,200.58	5,402.54 0.00% 600.28	8,974,924.21 5.54% 326.11	0.00 0.00% N/A	0.00 0.00% N/A	153,295,678.73 94.69% 1,938.73	144,320,754.52 89.14% 2,799.68	8,603,964.18 5.31% 75.07	161,899,642.91 100.00% 835.88

Eligibles age 18 and over exempt by the current Severe and Persistent Mental Illness Definition from January 2005 through May 2005

		Stimulant	Antipsychotic	Antidepressant	CRT	BHD	Schizophrenia
1	Number of Patients	812	6948	12126	2314	28147	545
	% of total population	1.01%	8.62%	15.05%	2.87%	34.94%	0.68%
2	Total Drug Cost	1,708,530.75	16,279,932.97	24,051,011.80	6,488,345.34	28,628,580.48	1,779,293.54
	% of Total Drug Cost	3.21%	30.60%	45.21%	12.20%	53.82%	3.34%
	Drug Cost Per Patient	2,104.10	2,343.11	1,983.43	2,803.95	1,017.11	3,264.76
3	Non-BH Drug Cost	689,607.29	6,200,881.89	13,962,832.61	1,856,511.52	15,799,650.88	460,524.15
	% of Non-BH Drug Cost	1.88%	16.88%	38.01%	5.05%	43.01%	1.25%
	Non-BH Drug Cost Per Patient	849.27	892.47	1,151.48	802.30	561.33	845.00
4	Antipsychotic Drug Cost	268,320.24	6,322,373.59	3,561,342.87	3,171,615.56	5,557,446.97	1,060,571.94
	% of Antipsychotic Drug Cost	4.24%	100.00%	56.33%	50.16%	87.90%	16.77%
	Antipsychotic Drug Cost Per Patient	330.44	909.96	293.69	1,370.62	197.44	1,946.00
5	Antidepressant Drug Cost	196,870.75	1,585,236.21	3,766,222.08	542,361.70	3,453,875.57	92,673.84
	% of Antidepressant Drug Cost	4.04%	32.52%	77.27%	11.13%	70.86%	1.90%
	Antidepressant Drug Cost Per Patient	242.45	228.16	310.59	234.38	122.71	170.04
6	Stimulant Drug Cost	353,443.73	184,907.30	270,234.37	65,724.02	390,740.37	6,125.55
	% of Stimulant Drug Cost	76.35%	39.94%	58.37%	14.20%	84.41%	1.32%
	Stimulant Drug Cost Per Patient	435.28	26.61	22.29	28.40	13.88	11.24
7	Total Exemptable BH Drug Cost	818,634.72	8,092,517.10	7,597,799.32	3,779,701.28	9,402,062.91	1,159,371.33
	% Total Exemptable BH Drug Cost	7.02%	69.41%	65.17%	32.42%	80.64%	9.94%
	Total Exemptable BH Drug Cost Per Patient	1,008.17	1,164.73	626.57	1,633.41	334.03	2,127.29
8	Anxiety and Sedative Hypnotic Drug Cost	38,315.27	314,198.53	485,986.04	122,497.12	545,595.68	19,536.59
	% of Anxiety and Sedative Hypnotic Drug Cost	4.52%	37.07%	57.34%	14.45%	64.38%	2.31%
	Anxiety and Sedative Hypnotic Drug Cost Per Patient	47.19	45.22	40.08	52.94	19.38	35.85
9	Mania Drug Cost	2,012.13	33,328.30	20,463.45	19,400.48	39,603.78	2,513.42
	% of Mania Drug Cost	4.58%	75.93%	46.62%	44.20%	90.23%	5.73%
	Mania Drug Cost Per Patient	2.48	4.80	1.69	8.38	1.41	4.61
10	Anticonvulsant Drug Cost	159,961.34	1,639,007.15	1,983,930.38	710,234.94	2,841,667.23	137,348.05
	% of Anticonvulsant Drug Cost	4.10%	41.97%	50.80%	18.19%	72.77%	3.52%
	Anticonvulsant Drug Cost Per Patient	197.00	235.90	163.61	306.93	100.96	252.01
11	Total Non-Exemptable BH Drug Cost	200,288.74	1,986,533.98	2,490,379.87	852,132.54	3,426,866.69	159,398.06
	% Non-Exemptable BH Drug Cost	4.18%	41.42%	51.92%	17.77%	71.45%	3.32%
	Total Non-Exemptable BH Drug Cost Per Patient	246.66	285.91	205.38	368.25	121.75	292.47
12	Total BH Drug Cost	1,018,923.46	10,079,051.08	10,088,179.19	4,631,833.82	12,828,929.60	1,318,769.39
	% BH Drug Cost	6.19%	61.25%	61.30%	28.15%	77.96%	8.01%
	Total BH Drug Cost Per Patient	1,254.83	1,450.64	831.95	2,001.66	455.78	2,419.76

Bipolar	Antipsychotic, CRT, or BHD	Stimulant or Antidepressant	Stimulant Only	Antipsychotic Only	Antidepressant Only	CRT Only	BHD Only	Schizophrenia Only	Bipolar Only
740	29374	12488	45	624	3507	6	14997	0	0
0.92%	36.46%	15.50%	0.06%	0.77%	4.35%	0.01%	18.62%	0.00%	0.00%
1,291,251.95	31,148,011.75	24,499,443.79	54,317.14	1,002,330.28	6,145,256.30	4,521.20	6,734,710.60	0.00	0.00
2.43%	58.56%	46.06%	0.10%	1.88%	11.55%	0.01%	12.66%	0.00%	0.00%
1,744.94	1,060.39	1,961.84	1,207.05	1,606.30	1,752.28	753.53	449.07	N/A	N/A
431,315.38	17,101,010.80	14,131,335.04	33,965.20	543,701.84	4,956,680.55	725.00	5,498,190.80	0.00	0.00
1.17%	46.55%	38.46%	0.09%	1.48%	13.49%	0.00%	14.97%	0.00%	0.00%
582.86	582.18	1,131.59	754.78	871.32	1,413.37	120.83	366.62	N/A	N/A
407,962.78	6,322,373.59	3,638,451.67	0.00	339,791.95	0.00	0.00	0.00	0.00	0.00
6.45%	100.00%	57.55%	0.00%	5.37%	0.00%	0.00%	0.00%	0.00%	0.00%
551.30	215.24	291.36	0.00	544.54	0.00	0.00	0.00	N/A	N/A
120,098.64	3,673,691.51	3,781,748.69	1,472.30	29,253.63	816,981.34	1,266.52	492,605.74	0.00	0.00
2.46%	75.37%	77.59%	0.03%	0.60%	16.76%	0.03%	10.11%	0.00%	0.00%
162.30	125.07	302.83	32.72	46.88	232.96	211.09	32.85	N/A	N/A
17,538.87	401,837.14	397,946.47	17,375.85	1,816.89	5,925.17	0.00	30,459.43	0.00	0.00
3.79%	86.80%	85.96%	3.75%	0.39%	1.28%	0.00%	6.58%	0.00%	0.00%
23.70	13.68	31.87	386.13	2.91	1.69	0.00	2.03	N/A	N/A
545,600.29	10,397,902.24	7,818,146.83	18,848.15	370,862.47	822,906.51	1,266.52	523,065.17	0.00	0.00
4.68%	89.18%	67.06%	0.16%	3.18%	7.06%	0.01%	4.49%	0.00%	0.00%
737.30	353.98	626.05	418.85	594.33	234.65	211.09	34.88	N/A	N/A
35,767.52	590,387.33	495,165.02	872.54	13,094.47	104,556.02	0.00	113,151.69	0.00	0.00
4.22%	69.66%	58.43%	0.10%	1.55%	12.34%	0.00%	13.35%	0.00%	0.00%
48.33	20.10	39.65	19.39	20.98	29.81	0.00	7.54	N/A	N/A
10,881.46	42,383.75	21,328.45	0.00	1,677.50	606.88	69.26	2,321.48	0.00	0.00
24.79%	96.57%	48.59%	0.00%	3.82%	1.38%	0.16%	5.29%	0.00%	0.00%
14.70	1.44	1.71	0.00	2.69	0.17	11.54	0.15	N/A	N/A
267,687.30	3,016,327.63	2,033,468.45	631.25	72,994.00	260,506.34	2,460.42	597,981.46	0.00	0.00
6.85%	77.24%	52.07%	0.02%	1.87%	6.67%	0.06%	15.31%	0.00%	0.00%
361.74	102.69	162.83	14.03	116.98	74.28	410.07	39.87	N/A	N/A
314,336.28	3,649,098.71	2,549,961.92	1,503.79	87,765.97	365,669.24	2,529.68	713,454.63	0.00	0.00
6.55%	76.08%	53.16%	0.03%	1.83%	7.62%	0.05%	14.87%	0.00%	0.00%
424.78	124.23	204.19	33.42	140.65	104.27	421.61	47.57	N/A	N/A
859,936.57	14,047,000.95	10,368,108.75	20,351.94	458,628.44	1,188,575.75	3,796.20	1,236,519.80	0.00	0.00
5.23%	85.36%	63.01%	0.12%	2.79%	7.22%	0.02%	7.51%	0.00%	0.00%
1,162.08	478.21	830.25	452.27	734.98	338.92	632.70	82.45	N/A	N/A

All Including BHD	SPMI Exempt: All Excluding BHD Only	No BHD or SPMI Exemption	Total: BHD Only, SPMI Exempt, No BHD or SPMI Exemption
32986 40.94% 	17989 22.33% 	47576 59.06% 	80562 100.00%
37,495,640.25 70.49% 1,136.71	30,760,929.65 57.83% 1,709.99	15,698,617.17 29.51% 329.97	53,194,257.42 100.00% 660.29
22,190,342.15 60.40% 672.72	16,692,151.35 45.44% 927.91	14,548,168.16 39.60% 305.79	36,738,510.31 100.00% 456.03
6,322,373.59 100.00% 191.67	6,322,373.59 100.00% 351.46	0.00 0.00% 0.00	6,322,373.59 100.00% 78.48
4,508,487.84 92.50% 136.68	4,015,882.10 82.39% 223.24	365,499.07 7.50% 7.68	4,873,986.91 100.00% 60.50
448,381.82 96.86% 13.59	417,922.39 90.28% 23.23	14,547.64 3.14% 0.31	462,929.46 100.00% 5.75
11,279,243.25 96.74% 341.94	10,756,178.08 92.25% 597.93	380,046.71 3.26% 7.99	11,659,289.96 100.00% 144.72
698,456.18 82.41% 21.17	585,304.49 69.06% 32.54	149,037.99 17.59% 3.13	847,494.17 100.00% 10.52
43,048.29 98.08% 1.31	40,726.81 92.79% 2.26	842.30 1.92% 0.02	43,890.59 100.00% 0.54
3,284,550.38 84.11% 99.57	2,686,568.92 68.80% 149.35	620,522.01 15.89% 13.04	3,905,072.39 100.00% 48.47
4,026,054.85 83.94% 122.05	3,312,600.22 69.06% 184.15	770,402.30 16.06% 16.19	4,796,457.15 100.00% 59.54
15,305,298.10 93.01% 463.99	14,068,778.30 85.49% 782.08	1,150,449.01 6.99% 24.18	16,455,747.11 100.00% 204.26

Eligibles age 18 and over exempt by the current Severe and Persistent Mental Illness Definition from January 2005 through May 2005

		Stimulant	Antipsychotic	Antidepressant	CRT	BHD	Schizophrenia
1	Number of Patients	812	6948	12126	2314	28147	545
	% of total population	1.01%	8.62%	15.05%	2.87%	34.94%	0.68%
2	Total Drug Cost	1,708,530.75	16,279,932.97	24,051,011.80	6,488,345.34	28,628,580.48	1,779,293.54
	% of Total Drug Cost	3.21%	30.60%	45.21%	12.20%	53.82%	3.34%
	Drug Cost Per Patient	2,104.10	2,343.11	1,983.43	2,803.95	1,017.11	3,264.76
3	Non-BH Drug Cost	689,607.29	6,200,881.89	13,962,832.61	1,856,511.52	15,799,650.88	460,524.15
	% of Non-BH Drug Cost	1.88%	16.88%	38.01%	5.05%	43.01%	1.25%
	Non-BH Drug Cost Per Patient	849.27	892.47	1,151.48	802.30	561.33	845.00
4	Antipsychotic Drug Cost	268,320.24	6,322,373.59	3,561,342.87	3,171,615.56	5,557,446.97	1,060,571.94
	% of Antipsychotic Drug Cost	4.24%	100.00%	56.33%	50.16%	87.90%	16.77%
	Antipsychotic Drug Cost Per Patient	330.44	909.96	293.69	1,370.62	197.44	1,946.00
5	Antidepressant Drug Cost	196,870.75	1,585,236.21	3,766,222.08	542,361.70	3,453,875.57	92,673.84
	% of Antidepressant Drug Cost	4.04%	32.52%	77.27%	11.13%	70.86%	1.90%
	Antidepressant Drug Cost Per Patient	242.45	228.16	310.59	234.38	122.71	170.04
6	Stimulant Drug Cost	353,443.73	184,907.30	270,234.37	65,724.02	390,740.37	6,125.55
	% of Stimulant Drug Cost	76.35%	39.94%	58.37%	14.20%	84.41%	1.32%
	Stimulant Drug Cost Per Patient	435.28	26.61	22.29	28.40	13.88	11.24
7	Total Exemptable BH Drug Cost	818,634.72	8,092,517.10	7,597,799.32	3,779,701.28	9,402,062.91	1,159,371.33
	% Total Exemptable BH Drug Cost	7.02%	69.41%	65.17%	32.42%	80.64%	9.94%
	Total Exemptable BH Drug Cost Per Patient	1,008.17	1,164.73	626.57	1,633.41	334.03	2,127.29
8	Anxiety and Sedative Hypnotic Drug Cost	38,315.27	314,198.53	485,986.04	122,497.12	545,595.68	19,536.59
	% of Anxiety and Sedative Hypnotic Drug Cost	4.52%	37.07%	57.34%	14.45%	64.38%	2.31%
	Anxiety and Sedative Hypnotic Drug Cost Per Patient	47.19	45.22	40.08	52.94	19.38	35.85
9	Mania Drug Cost	2,012.13	33,328.30	20,463.45	19,400.48	39,603.78	2,513.42
	% of Mania Drug Cost	4.58%	75.93%	46.62%	44.20%	90.23%	5.73%
	Mania Drug Cost Per Patient	2.48	4.80	1.69	8.38	1.41	4.61
10	Anticonvulsant Drug Cost	159,961.34	1,639,007.15	1,983,930.38	710,234.94	2,841,667.23	137,348.05
	% of Anticonvulsant Drug Cost	4.10%	41.97%	50.80%	18.19%	72.77%	3.52%
	Anticonvulsant Drug Cost Per Patient	197.00	235.90	163.61	306.93	100.96	252.01
11	Total Non-Exemptable BH Drug Cost	200,288.74	1,986,533.98	2,490,379.87	852,132.54	3,426,866.69	159,398.06
	% Non-Exemptable BH Drug Cost	4.18%	41.42%	51.92%	17.77%	71.45%	3.32%
	Total Non-Exemptable BH Drug Cost Per Patient	246.66	285.91	205.38	368.25	121.75	292.47
12	Total BH Drug Cost	1,018,923.46	10,079,051.08	10,088,179.19	4,631,833.82	12,828,929.60	1,318,769.39
	% BH Drug Cost	6.19%	61.25%	61.30%	28.15%	77.96%	8.01%
	Total BH Drug Cost Per Patient	1,254.83	1,450.64	831.95	2,001.66	455.78	2,419.76

Bipolar	Antipsychotic, CRT, or BHD	Stimulant or Antidepressant	Stimulant Only	Antipsychotic Only	Antidepressant Only	CRT Only	BHD Only	Schizophrenia Only	Bipolar Only
740	29374	12488	45	624	3507	6	14997	0	0
0.92%	36.46%	15.50%	0.06%	0.77%	4.35%	0.01%	18.62%	0.00%	0.00%
1,291,251.95	31,148,011.75	24,499,443.79	54,317.14	1,002,330.28	6,145,256.30	4,521.20	6,734,710.60	0.00	0.00
2.43%	58.56%	46.06%	0.10%	1.88%	11.55%	0.01%	12.66%	0.00%	0.00%
1,744.94	1,060.39	1,961.84	1,207.05	1,606.30	1,752.28	753.53	449.07	N/A	N/A
431,315.38	17,101,010.80	14,131,335.04	33,965.20	543,701.84	4,956,680.55	725.00	5,498,190.80	0.00	0.00
1.17%	46.55%	38.46%	0.09%	1.48%	13.49%	0.00%	14.97%	0.00%	0.00%
582.86	582.18	1,131.59	754.78	871.32	1,413.37	120.83	366.62	N/A	N/A
407,962.78	6,322,373.59	3,638,451.67	0.00	339,791.95	0.00	0.00	0.00	0.00	0.00
6.45%	100.00%	57.55%	0.00%	5.37%	0.00%	0.00%	0.00%	0.00%	0.00%
551.30	215.24	291.36	0.00	544.54	0.00	0.00	0.00	N/A	N/A
120,098.64	3,673,691.51	3,781,748.69	1,472.30	29,253.63	816,981.34	1,266.52	492,605.74	0.00	0.00
2.46%	75.37%	77.59%	0.03%	0.60%	16.76%	0.03%	10.11%	0.00%	0.00%
162.30	125.07	302.83	32.72	46.88	232.96	211.09	32.85	N/A	N/A
17,538.87	401,837.14	397,946.47	17,375.85	1,816.89	5,925.17	0.00	30,459.43	0.00	0.00
3.79%	86.80%	85.96%	3.75%	0.39%	1.28%	0.00%	6.58%	0.00%	0.00%
23.70	13.68	31.87	386.13	2.91	1.69	0.00	2.03	N/A	N/A
545,600.29	10,397,902.24	7,818,146.83	18,848.15	370,862.47	822,906.51	1,266.52	523,065.17	0.00	0.00
4.68%	89.18%	67.06%	0.16%	3.18%	7.06%	0.01%	4.49%	0.00%	0.00%
737.30	353.98	626.05	418.85	594.33	234.65	211.09	34.88	N/A	N/A
35,767.52	590,387.33	495,165.02	872.54	13,094.47	104,556.02	0.00	113,151.69	0.00	0.00
4.22%	69.66%	58.43%	0.10%	1.55%	12.34%	0.00%	13.35%	0.00%	0.00%
48.33	20.10	39.65	19.39	20.98	29.81	0.00	7.54	N/A	N/A
10,881.46	42,383.75	21,328.45	0.00	1,677.50	606.88	69.26	2,321.48	0.00	0.00
24.79%	96.57%	48.59%	0.00%	3.82%	1.38%	0.16%	5.29%	0.00%	0.00%
14.70	1.44	1.71	0.00	2.69	0.17	11.54	0.15	N/A	N/A
267,687.30	3,016,327.63	2,033,468.45	631.25	72,994.00	260,506.34	2,460.42	597,981.46	0.00	0.00
6.85%	77.24%	52.07%	0.02%	1.87%	6.67%	0.06%	15.31%	0.00%	0.00%
361.74	102.69	162.83	14.03	116.98	74.28	410.07	39.87	N/A	N/A
314,336.28	3,649,098.71	2,549,961.92	1,503.79	87,765.97	365,669.24	2,529.68	713,454.63	0.00	0.00
6.55%	76.08%	53.16%	0.03%	1.83%	7.62%	0.05%	14.87%	0.00%	0.00%
424.78	124.23	204.19	33.42	140.65	104.27	421.61	47.57	N/A	N/A
859,936.57	14,047,000.95	10,368,108.75	20,351.94	458,628.44	1,188,575.75	3,796.20	1,236,519.80	0.00	0.00
5.23%	85.36%	63.01%	0.12%	2.79%	7.22%	0.02%	7.51%	0.00%	0.00%
1,162.08	478.21	830.25	452.27	734.98	338.92	632.70	82.45	N/A	N/A

All Including BHD	SPMI Exempt: All Excluding BHD Only	No BHD or SPMI Exemption	Total: BHD Only, SPMI Exempt, No BHD or SPMI Exemption
32986 40.94% 	17989 22.33% 	47576 59.06% 	80562 100.00%
37,495,640.25 70.49% 1,136.71	30,760,929.65 57.83% 1,709.99	15,698,617.17 29.51% 329.97	53,194,257.42 100.00% 660.29
22,190,342.15 60.40% 672.72	16,692,151.35 45.44% 927.91	14,548,168.16 39.60% 305.79	36,738,510.31 100.00% 456.03
6,322,373.59 100.00% 191.67	6,322,373.59 100.00% 351.46	0.00 0.00% 0.00	6,322,373.59 100.00% 78.48
4,508,487.84 92.50% 136.68	4,015,882.10 82.39% 223.24	365,499.07 7.50% 7.68	4,873,986.91 100.00% 60.50
448,381.82 96.86% 13.59	417,922.39 90.28% 23.23	14,547.64 3.14% 0.31	462,929.46 100.00% 5.75
11,279,243.25 96.74% 341.94	10,756,178.08 92.25% 597.93	380,046.71 3.26% 7.99	11,659,289.96 100.00% 144.72
698,456.18 82.41% 21.17	585,304.49 69.06% 32.54	149,037.99 17.59% 3.13	847,494.17 100.00% 10.52
43,048.29 98.08% 1.31	40,726.81 92.79% 2.26	842.30 1.92% 0.02	43,890.59 100.00% 0.54
3,284,550.38 84.11% 99.57	2,686,568.92 68.80% 149.35	620,522.01 15.89% 13.04	3,905,072.39 100.00% 48.47
4,026,054.85 83.94% 122.05	3,312,600.22 69.06% 184.15	770,402.30 16.06% 16.19	4,796,457.15 100.00% 59.54
15,305,298.10 93.01% 463.99	14,068,778.30 85.49% 782.08	1,150,449.01 6.99% 24.18	16,455,747.11 100.00% 204.26

Eligibles under the age of 18 exempt by the current Severe and Persistent Mental Illness Definition from January 2002 through May 2005

		Stimulant	Antipsychotic	Antidepressant	CRT	BHD	Schizophrenia
1	Number of Patients	3764	2594	2399	57	26715	24
	% of total population	5.07%	3.50%	3.23%	0.08%	36.01%	0.03%
2	Total Drug Cost	18,927,005.00	17,618,618.87	15,368,851.50	535,983.69	47,848,268.12	315,253.61
	% of Total Drug Cost	27.74%	25.82%	22.52%	0.79%	70.13%	0.46%
	Drug Cost Per Patient	5,028.43	6,792.07	6,406.36	9,403.22	1,791.06	13,135.57
3	Non-BH Drug Cost	3,351,059.65	3,000,938.38	3,367,015.81	58,758.48	21,401,786.99	52,999.74
	% of Non-BH Drug Cost	8.17%	7.31%	8.20%	0.14%	52.15%	0.13%
	Non-BH Drug Cost Per Patient	890.29	1,156.88	1,403.51	1,030.85	801.11	2,208.32
4	Antipsychotic Drug Cost	3,912,873.44	7,636,088.89	3,904,769.29	296,068.28	7,543,980.23	207,724.55
	% of Antipsychotic Drug Cost	51.24%	100.00%	51.14%	3.88%	98.79%	2.72%
	Antipsychotic Drug Cost Per Patient	1,039.55	2,943.75	1,627.67	5,194.18	282.39	8,655.19
5	Antidepressant Drug Cost	1,964,419.40	2,085,693.79	4,044,080.09	56,091.38	5,321,094.48	11,461.58
	% of Antidepressant Drug Cost	35.86%	38.08%	73.83%	1.02%	97.14%	0.21%
	Antidepressant Drug Cost Per Patient	521.90	804.05	1,685.74	984.06	199.18	477.57
6	Stimulant Drug Cost	8,588,061.52	3,052,145.23	2,839,170.63	25,191.04	9,417,669.47	6,203.26
	% of Stimulant Drug Cost	88.94%	31.61%	29.40%	0.26%	97.53%	0.06%
	Stimulant Drug Cost Per Patient	2,281.63	1,176.62	1,183.48	441.95	352.52	258.47
7	Total Exemptable BH Drug Cost	14,465,354.36	12,773,927.91	10,788,020.01	377,350.70	22,282,744.18	225,389.39
	% Total Exemptable BH Drug Cost	63.53%	56.10%	47.38%	1.66%	97.86%	0.99%
	Total Exemptable BH Drug Cost Per Patient	3,843.08	4,924.41	4,496.88	6,620.19	834.09	9,391.22
8	Anxiety and Sedative Hypnotic Drug Cost	38,355.54	69,951.04	66,250.13	3,046.09	150,134.38	1,036.70
	% of Anxiety and Sedataive Hypnotic Drug Cost	23.47%	42.81%	40.54%	1.86%	91.88%	0.63%
	Anxiety and Sedative Hypnotic Drug Cost Per Patient	10.19	26.97	27.62	53.44	5.62	43.20
9	Mania Drug Cost	38,604.63	93,189.22	46,301.16	4,063.47	102,017.36	4,415.82
	% of Mania Drug Cost	37.72%	91.05%	45.24%	3.97%	99.67%	4.31%
	Mania Drug Cost Per Patient	10.26	35.92	19.30	71.29	3.82	183.99
10	Anticonvulsant Drug Cost	1,033,630.82	1,680,612.32	1,101,264.39	92,764.95	3,911,585.21	31,411.96
	% of Anticonvulsant Drug Cost	24.86%	40.42%	26.49%	2.23%	94.08%	0.76%
	Anticonvulsant Drug Cost Per Patient	274.61	647.88	459.05	1,627.46	146.42	1,308.83
11	Total Non-Exemptable BH Drug Cost	1,110,590.99	1,843,752.58	1,213,815.68	99,874.51	4,163,736.95	36,864.48
	% Non-Exemptable BH Drug Cost	25.11%	41.68%	27.44%	2.26%	94.13%	0.83%
	Total Non-Exemptable BH Drug Cost Per Patient	295.06	710.78	505.97	1,752.18	155.86	1,536.02
12	Total BH Drug Cost	15,575,945.35	14,617,680.49	12,001,835.69	477,225.21	26,446,481.13	262,253.87
	% Total BH Drug Cost	57.28%	53.76%	44.14%	1.75%	97.26%	0.96%
	Total BH Drug Cost Per Patient	4,138.14	5,635.19	5,002.85	8,372.37	989.95	10,927.24

Bipolar	Antipsychotic, CRT, or BHD	Stimulant or Antidepressant	SPMI Exempt: All, No BHD Only	No SPMI Exemption	Total: BHD Only, SPMI Exempt, No BHD or SPMI Exemption
406 0.55% 	26794 36.12% 	5189 7.00% 	26956 36.34% 	47225 63.66% 	74181 100.00%
2,748,658.35 4.03% 6,770.09	48,018,694.16 70.38% 1,792.14	25,911,248.11 37.98% 4,993.50	48,439,938.23 70.99% 1,797.00	19,791,825.03 29.01% 419.10	68,231,763.26 100.00% 919.80
366,459.67 0.89% 902.61	21,439,226.91 52.24% 800.15	5,474,153.01 13.34% 1,054.95	21,665,526.91 52.79% 803.74	19,373,377.13 47.21% 410.24	41,038,904.04 100.00% 553.23
1,260,210.09 16.50% 3,103.97	7,636,088.89 100.00% 284.99	5,709,747.85 74.77% 1,100.36	7,636,088.89 100.00% 283.28	0.00 0.00% 0.00	7,636,088.89 100.00% 102.94
305,479.62 5.58% 752.41	5,340,185.60 97.49% 199.31	4,279,713.75 78.13% 824.77	5,390,174.41 98.40% 199.96	87,452.20 1.60% 1.85	5,477,626.61 100.00% 73.84
350,462.00 3.63% 863.21	9,426,273.37 97.62% 351.81	8,668,537.65 89.78% 1,670.56	9,564,763.20 99.06% 354.83	91,009.26 0.94% 1.93	9,655,772.46 100.00% 130.17
1,916,151.71 8.42% 4,719.59	22,402,547.86 98.39% 836.10	18,657,999.25 81.94% 3,595.68	22,591,026.50 99.22% 838.07	178,461.46 0.78% 3.78	22,769,487.96 100.00% 306.95
4,379.07 2.68% 10.79	152,901.75 93.57% 5.71	82,181.75 50.29% 15.84	153,779.95 94.11% 5.70	9,629.19 5.89% 0.20	163,409.14 100.00% 2.20
49,446.94 48.31% 121.79	102,297.62 99.95% 3.82	70,223.01 68.61% 13.53	102,351.01 100.00% 3.80	0.00 0.00% 0.00	102,351.01 100.00% 1.38
412,220.96 9.91% 1,015.32	3,921,720.02 94.33% 146.37	1,626,691.09 39.13% 313.49	3,927,253.86 94.46% 145.69	230,357.25 5.54% 4.88	4,157,611.11 100.00% 56.05
466,046.97 10.54% 1,147.90	4,176,919.39 94.43% 155.89	1,779,095.85 40.22% 342.86	4,183,384.82 94.57% 155.19	239,986.44 5.43% 5.08	4,423,371.26 100.00% 59.63
2,382,198.68 8.76% 5,867.48	26,579,467.25 97.74% 991.99	20,437,095.10 75.16% 3,938.54	26,774,411.32 98.46% 993.26	418,447.90 1.54% 8.86	27,192,859.22 100.00% 366.57

All eligibles exempt by the current Severe and Persistent Mental Illness Definition from January 2005 through May 2005

		Stimulant	Antipsychotic	Juv02	Juv03	Juv04	Juv05
1	Number of Patients	3326	8462	46796	45605	44254	42697
	% of total population	2.70%	6.87%	37.97%	37.00%	35.90%	34.64%
2	Total Drug Cost	3,965,571.70	18,306,885.14	8,710,840.39	8,363,987.62	8,001,469.62	7,687,044.44
	% of Total Drug Cost	6.51%	30.07%	14.31%	13.74%	13.14%	12.63%
	Drug Cost Per Patient	1,192.29	2,163.42	186.14	183.40	180.81	180.04
3	Non-BH Drug Cost	1,056,086.57	6,461,202.92	4,997,326.99	4,818,724.03	4,618,588.04	4,481,344.58
	% of Non-BH Drug Cost	2.56%	15.67%	12.12%	11.69%	11.20%	10.87%
	Non-BH Drug Cost Per Patient	317.52	763.56	106.79	105.66	104.37	104.96
4	Antipsychotic Drug Cost	811,434.45	7,313,740.23	1,191,576.25	1,115,565.90	1,062,559.08	991,366.64
	% of Antipsychotic Drug Cost	11.09%	100.00%	16.29%	15.25%	14.53%	13.55%
	Antipsychotic Drug Cost Per Patient	243.97	864.30	25.46	24.46	24.01	23.22
5	Antidepressant Drug Cost	347,652.06	1,747,794.03	538,095.81	499,632.30	465,300.11	426,928.34
	% of Antidepressant Drug Cost	6.56%	32.97%	10.15%	9.43%	8.78%	8.05%
	Antidepressant Drug Cost Per Patient	104.53	206.55	11.50	10.96	10.51	10.00
6	Stimulant Drug Cost	1,418,508.07	571,571.25	1,348,400.05	1,336,106.38	1,319,798.90	1,284,300.03
	% of Stimulant Drug Cost	81.19%	32.71%	77.17%	76.47%	75.54%	73.50%
	Stimulant Drug Cost Per Patient	426.49	67.55	28.81	29.30	29.82	30.08
7	Total Exemptable BH Drug Cost	2,577,594.58	9,633,105.51	3,078,072.11	2,951,304.58	2,847,658.09	2,702,595.01
	% Total Exemptable BH Drug Cost	17.95%	67.07%	21.43%	20.55%	19.83%	18.82%
	Total Exemptable BH Drug Cost Per Patient	774.98	1,138.40	65.78	64.71	64.35	63.30
8	Anxiety and Sedative Hypnotic Drug Cost	40,877.51	319,396.85	17,136.16	14,058.84	11,106.63	10,057.20
	% of Anxiety and Sedative Hypnotic Drug Cost	4.77%	37.25%	2.00%	1.64%	1.30%	1.17%
	Anxiety and Sedative Hypnotic Drug Cost Per Patient	12.29	37.74	0.37	0.31	0.25	0.24
9	Mania Drug Cost	7,400.87	43,477.02	13,067.49	12,497.77	12,234.30	11,149.99
	% of Mania Drug Cost	13.45%	78.99%	23.74%	22.71%	22.23%	20.26%
	Mania Drug Cost Per Patient	2.23	5.14	0.28	0.27	0.28	0.26
10	Anticonvulsant Drug Cost	283,612.17	1,849,702.84	605,237.64	567,402.40	511,882.56	481,897.66
	% of Anticonvulsant Drug Cost	6.46%	42.16%	13.80%	12.93%	11.67%	10.98%
	Anticonvulsant Drug Cost Per Patient	85.27	218.59	12.93	12.44	11.57	11.29
11	Total Non-Exemptable BH Drug Cost	331,890.55	2,212,576.71	635,441.29	593,959.01	535,223.49	503,104.85
	% Non-Exemptable BH Drug Cost	6.26%	41.75%	11.99%	11.21%	10.10%	9.49%
	Total Non-Exemptable BH Drug Cost Per Patient	99.79	261.47	13.58	13.02	12.09	11.78
12	Total BH Drug Cost	2,909,485.13	11,845,682.22	3,713,513.40	3,545,263.59	3,382,881.58	3,205,699.86
	% Total BH Drug Cost	14.80%	60.25%	18.89%	18.03%	17.21%	16.30%
	Total BH Drug Cost Per Patient	874.77	1,399.87	79.36	77.74	76.44	75.08

Antidepressant	CRT	BHD	Schizophrenia	Bipolar	Antipsychotic, CRT, or BHD	Stimulant or Antidepressant	Stimulant Only	Antipsychotic Only	Antidepressant Only
13488 10.94%	2314 1.88%	43600 35.37%	554 0.45%	965 0.78%	44863 36.40%	15724 12.76%	45 0.04%	624 0.51%	3507 2.85%
25,448,646.11 41.80% 1,886.76	6,488,345.34 10.66% 2,803.95	33,787,371.57 55.50% 774.94	1,800,420.15 2.96% 3,249.86	1,598,487.61 2.63% 1,656.46	36,344,224.22 59.70% 810.12	27,319,879.45 44.87% 1,737.46	54,317.14 0.09% 1,207.05	1,002,330.28 1.65% 1,606.30	6,145,256.30 10.09% 1,752.28
14,237,846.07 34.54% 1,055.59	1,856,511.52 4.50% 802.30	17,882,564.59 43.38% 410.15	464,680.33 1.13% 838.77	466,523.32 1.13% 483.44	19,191,616.70 46.56% 427.78	14,662,822.70 35.57% 932.51	33,965.20 0.08% 754.78	543,701.84 1.32% 871.32	4,956,680.55 12.02% 1,413.37
3,979,474.07 54.41% 295.04	3,171,615.56 43.37% 1,370.62	6,528,737.46 89.27% 149.74	1,074,501.58 14.69% 1,939.53	561,651.72 7.68% 582.02	7,313,740.23 100.00% 163.02	4,340,626.38 59.35% 276.05	0.00 0.00% 0.00	339,791.95 4.65% 544.54	0.00 0.00% 0.00
4,066,131.75 76.71% 301.46	542,361.70 10.23% 234.38	3,861,970.18 72.85% 88.58	93,032.89 1.76% 167.93	140,723.00 2.65% 145.83	4,085,739.69 77.08% 91.07	4,103,828.72 77.42% 260.99	1,472.30 0.03% 32.72	29,253.63 0.55% 46.88	816,981.34 15.41% 232.96
569,594.94 32.60% 42.23	65,724.02 3.76% 28.40	1,626,423.02 93.09% 37.30	6,875.28 0.39% 12.41	64,737.15 3.71% 67.09	1,639,873.18 93.86% 36.55	1,478,154.67 84.60% 94.01	17,375.85 0.99% 386.13	1,816.89 0.10% 2.91	5,925.17 0.34% 1.69
8,615,200.76 59.99% 638.73	3,779,701.28 26.32% 1,633.41	12,017,130.66 83.67% 275.62	1,174,409.75 8.18% 2,119.87	767,111.87 5.34% 794.93	13,039,353.10 90.79% 290.65	9,922,609.77 69.09% 631.05	18,848.15 0.13% 418.85	370,862.47 2.58% 594.33	822,906.51 5.73% 234.65
489,153.44 57.04% 36.27	122,497.12 14.28% 52.94	554,522.32 64.66% 12.72	19,536.59 2.28% 35.26	36,160.87 4.22% 37.47	599,569.13 69.92% 13.36	499,888.74 58.29% 31.79	872.54 0.10% 19.39	13,094.47 1.53% 20.98	104,556.02 12.19% 29.81
25,226.90 45.83% 1.87	19,400.48 35.25% 8.38	50,610.51 91.95% 1.16	2,804.58 5.10% 5.06	14,913.40 27.10% 15.45	53,533.74 97.26% 1.19	29,197.35 53.05% 1.86	0.00 0.00% 0.00	1,677.50 3.05% 2.69	606.88 1.10% 0.17
2,081,218.94 47.44% 154.30	710,234.94 16.19% 306.93	3,282,543.49 74.82% 75.29	138,988.90 3.17% 250.88	313,778.15 7.15% 325.16	3,460,151.55 78.87% 77.13	2,205,360.89 50.27% 140.25	631.25 0.01% 14.03	72,994.00 1.66% 116.98	260,506.34 5.94% 74.28
2,595,599.28 48.98% 192.44	852,132.54 16.08% 368.25	3,887,676.32 73.36% 89.17	161,330.07 3.04% 291.21	364,852.42 6.88% 378.09	4,113,254.42 77.61% 91.68	2,734,446.98 51.60% 173.90	1,503.79 0.03% 33.42	87,765.97 1.66% 140.65	365,669.24 6.90% 104.27
11,210,800.04 57.02% 831.17	4,631,833.82 23.56% 2,001.66	15,904,806.98 80.89% 364.79	1,335,739.82 6.79% 2,411.08	1,131,964.29 5.76% 1,173.02	17,152,607.52 87.24% 382.33	12,657,056.75 64.38% 804.95	20,351.94 0.10% 452.27	458,628.44 2.33% 734.98	1,188,575.75 6.05% 338.92

CRT Only	BHD Only	Schizophrenia Only	Bipolar Only	All Including BHD	SPMI Exempt: All Excluding BHD Only	No BHD or SPMI Exemption	Total: BHD Only, SPMI Exempt, No BHD or SPMI Exemption
6	14997	0	0	48561	33564	74698	123259
0.00%	12.17%	0.00%	0.00%	39.40%	27.23%	60.60%	100.00%
4,521.20	6,734,710.60	0.00	0.00	42,727,030.13	35,992,319.53	18,154,271.73	60,881,301.86
0.01%	11.06%	0.00%	0.00%	70.18%	59.12%	29.82%	100.00%
753.53	449.07	N/A	N/A	879.86	1,072.35	243.04	493.93
725.00	5,498,190.80	0.00	0.00	24,288,535.24	18,790,344.44	16,931,319.65	41,219,854.89
0.00%	13.34%	0.00%	0.00%	58.92%	45.59%	41.08%	100.00%
120.83	366.62	N/A	N/A	500.17	559.84	226.66	334.42
0.00	0.00	0.00	0.00	7,313,740.23	7,313,740.23	0.00	7,313,740.23
0.00%	0.00%	0.00%	0.00%	100.00%	100.00%	0.00%	100.00%
0.00	0.00	N/A	N/A	150.61	217.90	0.00	59.34
1,266.52	492,605.74	0.00	0.00	4,926,169.55	4,433,563.81	374,745.70	5,300,915.25
0.02%	9.29%	0.00%	0.00%	92.93%	83.64%	7.07%	100.00%
211.09	32.85	N/A	N/A	101.44	132.09	5.02	43.01
0.00	30,459.43	0.00	0.00	1,707,692.77	1,677,233.34	39,536.72	1,747,229.49
0.00%	1.74%	0.00%	0.00%	97.74%	95.99%	2.26%	100.00%
0.00	2.03	N/A	N/A	35.17	49.97	0.53	14.18
1,266.52	523,065.17	0.00	0.00	13,947,602.55	13,424,537.38	414,282.42	14,361,884.97
0.01%	3.64%	0.00%	0.00%	97.12%	93.47%	2.88%	100.00%
211.09	34.88	N/A	N/A	287.22	399.97	5.55	116.52
0.00	113,151.69	0.00	0.00	707,637.98	594,486.29	149,913.39	857,551.37
0.00%	13.19%	0.00%	0.00%	82.52%	69.32%	17.48%	100.00%
0.00	7.54	N/A	N/A	14.57	17.71	2.01	6.96
69.26	2,321.48	0.00	0.00	54,198.28	51,876.80	842.30	55,040.58
0.13%	4.22%	0.00%	0.00%	98.47%	94.25%	1.53%	100.00%
11.54	0.15	N/A	N/A	1.12	1.55	0.01	0.45
2,460.42	597,981.46	0.00	0.00	3,729,056.08	3,131,074.62	657,913.97	4,386,970.05
0.06%	13.63%	0.00%	0.00%	85.00%	71.37%	15.00%	100.00%
410.07	39.87	N/A	N/A	76.79	93.29	8.81	35.59
2,529.68	713,454.63	0.00	0.00	4,490,892.34	3,777,437.71	808,669.66	5,299,562.00
0.05%	13.46%	0.00%	0.00%	84.74%	71.28%	15.26%	100.00%
421.61	47.57	N/A	N/A	92.48	112.54	10.83	43.00
3,796.20	1,236,519.80	0.00	0.00	18,438,494.89	17,201,975.09	1,222,952.08	19,661,446.97
0.02%	6.29%	0.00%	0.00%	93.78%	87.49%	6.22%	100.00%
632.70	82.45	N/A	N/A	379.70	512.51	16.37	159.51

Eligibles under the age of 18 exempt by the current Severe and Persistent Mental Illness Definition from January 2005 through May 2005

		Stimulant	Antipsychotic	Antidepressant	CRT	BHD	Schizophrenia
1	Number of Patients	2514	1514	1362	0	15453	9
	% of total population	5.89%	3.55%	3.19%	0.00%	36.19%	0.02%
2	Total Drug Cost	2,257,040.95	2,026,952.17	1,397,634.31	0.00	5,158,791.09	21,126.61
	% of Total Drug Cost	29.36%	26.37%	18.18%	0.00%	67.11%	0.27%
	Drug Cost Per Patient	897.79	1,338.81	1,026.16	N/A	333.84	2,347.40
3	Non-BH Drug Cost	366,479.28	260,321.03	275,013.46	0.00	2,082,913.71	4,156.18
	% of Non-BH Drug Cost	8.18%	5.81%	6.14%	0.00%	46.48%	0.09%
	Non-BH Drug Cost Per Patient	145.78	171.94	201.92	N/A	134.79	461.80
4	Antipsychotic Drug Cost	543,114.21	991,366.64	418,131.20	0.00	971,290.49	13,929.64
	% of Antipsychotic Drug Cost	54.78%	100.00%	42.18%	0.00%	97.97%	1.41%
	Antipsychotic Drug Cost Per Patient	216.04	654.80	307.00	N/A	62.85	1,547.74
5	Antidepressant Drug Cost	150,781.31	162,557.82	299,909.67	0.00	408,094.61	359.05
	% of Antidepressant Drug Cost	35.32%	38.08%	70.25%	0.00%	95.59%	0.08%
	Antidepressant Drug Cost Per Patient	59.98	107.37	220.20	N/A	26.41	39.89
6	Stimulant Drug Cost	1,065,064.34	386,663.95	299,360.57	0.00	1,235,682.65	749.73
	% of Stimulant Drug Cost	82.93%	30.11%	23.31%	0.00%	96.21%	0.06%
	Stimulant Drug Cost Per Patient	423.65	255.39	219.79	N/A	79.96	83.30
7	Total Exemptable BH Drug Cost	1,758,959.86	1,540,588.41	1,017,401.44	0.00	2,615,067.75	15,038.42
	% Total Exemptable BH Drug Cost	65.08%	57.00%	37.65%	0.00%	96.76%	0.56%
	Total Exemptable BH Drug Cost Per Patient	699.67	1,017.56	746.99	N/A	169.23	1,670.94
8	Anxietyand Sedative Hypnotic Drug Cost	2,562.24	5,198.32	3,167.40	0.00	8,926.64	0.00
	% of Anxiety and Sedative Hypnotic Drug Cost	25.48%	51.69%	31.49%	0.00%	88.76%	0.00%
	Anxiety and Sedative Hypnotic Drug Cost Per Patient	1.02	3.43	2.33	N/A	0.58	0.00
9	Mania Drug Cost	5,388.74	10,148.72	4,763.45	0.00	11,006.73	291.16
	% of Mania Drug Cost	48.33%	91.02%	42.72%	0.00%	98.72%	2.61%
	Mania Drug Cost Per Patient	2.14	6.70	3.50	N/A	0.71	32.35
10	Anticonvulsant Drug Cost	123,650.83	210,695.69	97,288.56	0.00	440,876.26	1,640.85
	% of Anticonvulsant Drug Cost	25.66%	43.72%	20.19%	0.00%	91.49%	0.34%
	Anticonvulsant Drug Cost Per Patient	49.18	139.16	71.43	N/A	28.53	182.32
11	Total Non-Exemptable BH Drug Cost	131,601.81	226,042.73	105,219.41	0.00	460,809.63	1,932.01
	% Non-Exemptable BH Drug Cost	26.16%	44.93%	20.91%	0.00%	91.59%	0.38%
	Total Non-Exemptable BH Drug Cost Per Patient	52.35	149.30	77.25	N/A	29.82	214.67
12	Total BH Drug Cost	1,890,561.67	1,766,631.14	1,122,620.85	0.00	3,075,877.38	16,970.43
	% Total BH Drug Cost	58.98%	55.11%	35.02%	0.00%	95.95%	0.53%
	Total BH Drug Cost Per Patient	752.01	1,166.86	824.24	N/A	199.05	1,885.60

Bipolar	Antipsychotic, CRT, or BHD	Stimulant or Antidepressant	SPMI Exempt: All, No BHD Only	No SPMI Exemption	Total: BHD Only, SPMI Exempt, No BHD or SPMI Exemption
225 0.53% 1,365.49	15489 36.28% 335.48	3236 7.58% 871.58	15575 36.48% 335.88	27122 63.52% 90.54	42697 100.00% 180.04
307,235.66 4.00% 1,365.49	5,196,212.47 67.60% 335.48	2,820,435.66 36.69% 871.58	5,231,389.88 68.05% 335.88	2,455,654.56 31.95% 90.54	7,687,044.44 100.00% 180.04
35,207.94 0.79% 156.48	2,090,605.90 46.65% 134.97	531,487.66 11.86% 164.24	2,098,193.09 46.82% 134.72	2,383,151.49 53.18% 87.87	4,481,344.58 100.00% 104.96
153,688.94 15.50% 683.06	991,366.64 100.00% 64.00	702,174.71 70.83% 216.99	991,366.64 100.00% 63.65	0.00 0.00% 0.00	991,366.64 100.00% 23.22
20,624.36 4.83% 91.66	412,048.18 96.51% 26.60	322,080.03 75.44% 99.53	417,681.71 97.83% 26.82	9,246.63 2.17% 0.34	426,928.34 100.00% 10.00
47,198.28 3.68% 209.77	1,238,036.04 96.40% 79.93	1,080,208.20 84.11% 333.81	1,259,310.95 98.05% 80.85	24,989.08 1.95% 0.92	1,284,300.03 100.00% 30.08
221,511.58 8.20% 984.50	2,641,450.86 97.74% 170.54	2,104,462.94 77.87% 650.33	2,668,359.30 98.73% 171.32	34,235.71 1.27% 1.26	2,702,595.01 100.00% 63.30
393.35 3.91% 1.75	9,181.80 91.30% 0.59	4,723.72 46.97% 1.46	9,181.80 91.30% 0.59	875.40 8.70% 0.03	10,057.20 100.00% 0.24
4,031.94 36.16% 17.92	11,149.99 100.00% 0.72	7,868.90 70.57% 2.43	11,149.99 100.00% 0.72	0.00 0.00% 0.00	11,149.99 100.00% 0.26
46,090.85 9.56% 204.85	443,823.92 92.10% 28.65	171,892.44 35.67% 53.12	444,505.70 92.24% 28.54	37,391.96 7.76% 1.38	481,897.66 100.00% 11.29
50,516.14 10.04% 224.52	464,155.71 92.26% 29.97	184,485.06 36.67% 57.01	464,837.49 92.39% 29.85	38,267.36 7.61% 1.41	503,104.85 100.00% 11.78
272,027.72 8.49% 1,209.01	3,105,606.57 96.88% 200.50	2,288,948.00 71.40% 707.34	3,133,196.79 97.74% 201.17	72,503.07 2.26% 2.67	3,205,699.86 100.00% 75.08

Expenditures by Therapeutic class from January 2002 through May 2005

Antipsychotics

HIC 3	Therapeutic Class Description	Number of Rxs	Amount Paid / Class	Average Cost/ Rx	Average Quantity/ Rx	Average Days Supply/ Rx	Certified Brand	% Brand Utilization
All		305005	$ 56,860,935.81	$ 186.43	52	25.6	268278	87.96%
H2G	ANTI-PSYCHOTICS,PHENOTHIAZINES	19768	$ 538,460.70	$ 27.24	63	27.7	6103	30.87%
H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	11772	$ 315,832.77	$ 26.83	43	24.1	9827	83.48%
H7P	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, THIOXANTHENES	1876	$ 56,783.10	$ 30.27	85	29.9	177	9.43%
H7R	ANTIPSYCH,DOPAMINE ANTAG.,DIPHENYLBUTYLPIPERIDINES	203	$ 6,402.51	$ 31.54	32	20.8	203	100.00%
H7S	ANTIPSYCHOTICS,DOPAMINE ANTAGONST,DIHYDROINDOLONES	293	$ 51,178.03	$ 174.67	87	28.7	293	100.00%
H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	255289	$ 51,061,230.88	$ 200.01	52	25.4	236217	92.53%
H7U	ANTIPSYCHOTICS, DOPAMINE & SEROTONIN ANTAGONISTS	727	$ 52,464.42	$ 72.17	52	22.6	381	52.41%
H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	14914	$ 4,730,880.43	$ 317.21	31	26.9	14914	100.00%
H7Z	SSRI &ANTIPSYCH,ATYP,DOPAMINE&SEROTONIN ANTAG COMB	163	$ 47,702.97	$ 292.66	33	30.3	163	100.00%

Antidepressants

Drug Therapeutic Class	Therapeutic Class Description	Number of Rxs	Amount Paid / Class	Average Cost/ Rx	Average Quantity/ Rx	Average Days Supply/ Rx	Certified Brand	% Brand Utilization
All		802827	$ 48,836,742.27	$ 60.83	42	30.1	454401	56.60%
H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	436723	$ 30,501,687.90	$ 69.84	38	30.4	314909	72.11%
H2U	TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB	94945	$ 1,013,459.62	$ 10.67	52	31.3	1468	1.55%
H2W	TRICYCLIC ANTIDEPRESSANT/PHENOTHIAZINE COMBINATNS	509	$ 4,793.75	$ 9.42	74	34.5	127	24.95%
H2X	TRICYCLIC ANTIDEPRESSANT/BENZODIAZEPINE COMBINATNS	670	$ 24,526.46	$ 36.61	53	34.4	3	0.45%
H7B	ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS	27448	$ 1,603,088.55	$ 58.40	31	28.8	11802	43.00%
H7C	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	60863	$ 6,874,646.76	$ 112.95	43	29.0	60863	100.00%
H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	85457	$ 7,358,759.82	$ 86.11	52	29.6	57583	67.38%
H7E	SEROTONIN-2 ANTAGONIST/ REUPTAKE INHIBITOR	95559	$ 1,409,383.07	$ 14.75	45	29.0	6993	7.32%
H7J	MAOIS - NON-SELECTIVE & IRREVERSIBLE	653	$ 46,396.34	$ 71.05	128	28.8	653	100.00%

CNS Stimulants

Drug Therapeutic Class	Therapeutic Class Description	Number of Rxs	Amount Paid / Class	Average Cost/ Rx	Average Quantity/ Rx	Average Days Supply/ Rx	Certified Brand	% Brand Utilization
All		154604	$ 12,177,116.04	$ 78.76	44	28.9	116170	75.14%
H2A	CENTRAL NERVOUS SYSTEM STIMULANTS	194	$ 13,505.85	$ 69.62	48	26.8	97	50.00%
H2V	TX FOR ATTENTION DEFICIT-HYPERACT(ADHD)/NARCOLEPSY	94111	$ 6,891,543.32	$ 73.23	44	29.0	66611	70.78%
H7W	ANTI-NARCOLEPSY & ANTI-CATAPLEXY,SEDATIVE-TYPE AGT	67	$ 23,061.47	$ 344.20	261	23.9	67	100.00%
H7Y	TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE	20156	$ 2,150,945.41	$ 106.71	38	28.9	20156	100.00%
J5B	ADRENERGICS, AROMATIC, NON-CATECHOLAMINE	40076	$ 3,098,059.99	$ 77.30	49	28.9	29239	72.96%

Antianxiety and Sedative Hypnotics

Drug Therapeutic Class	Therapeutic Class Description	Number of Rxs	Amount Paid / Class	Average Cost/ Rx	Average Quantity/ Rx	Average Days Supply/ Rx	Certified Brand	% Brand Utilization
All		325402	$ 8,247,536.98	$ 25.35	49	23.5	74395	22.86%
H2D	BARBITURATES	13645	$ 67,142.48	$ 4.92	94	28.5	5878	43.08%
H2E	SEDATIVE-HYPNOTICS,NON-BARBITURATE	86141	$ 4,668,445.50	$ 54.20	31	25.3	64782	75.20%
H2F	ANTI-ANXIETY DRUGS	225616	$ 3,511,949.00	$ 15.57	53	22.5	3735	1.66%

Mania

Drug Therapeutic Class	Therapeutic Class Description	Number of Rxs	Amount Paid / Class	Average Cost/ Rx	Average Quantity/ Rx	Average Days Supply/ Rx	Certified Brand	% Brand Utilization
H2M	ANTI-MANIA DRUGS	23760	$ 527,246.14	$ 22.19	82	28.1	8319	35.01%

Anticonvulsants

Drug Therapeutic Class	Therapeutic Class Description	Number of Rxs	Amount Paid / Class	Average Cost/ Rx	Average Quantity/ Rx	Average Days Supply/ Rx	Certified Brand	% Brand Utilization
H4B	ANTICONVULSANTS	385287	$ 35,264,449.19	$ 91.53	93	28.0	240160	62.33%

Expenditures by Therapeutic class from January 2005 through May 2005

Antipsychotics

HIC 3	Therapeutic Class Description	Number of Rxs	Amount Paid / Class	Average Cost/ Rx	Average Quantity/ Rx	Average Days Supply/ Rx	Certified Brand	% Brand Utilization
All		46212	$ 9,416,651.60	$ 203.77	49	24.5	41662	90.15%
H2G	ANTI-PSYCHOTICS,PHENOTHIAZINES	2192	$ 63,422.70	$ 28.93	62	26.5	1017	46.40%
H7O	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS,BUTYROPHENONES	1617	$ 40,158.76	$ 24.84	37	20.7	1469	90.85%
H7P	ANTIPSYCHOTICS,DOPAMINE ANTAGONISTS, THIOXANTHENES	241	$ 6,656.60	$ 27.62	74	23.5	15	6.22%
H7R	ANTIPSYCH,DOPAMINE ANTAG.,DIPHENYLBUTYLPIPERIDINES	20	$ 921.06	$ 46.05	39	26.5	20	100.00%
H7S	ANTIPSYCHOTICS,DOPAMINE ANTAGONST,DIHYDROINDOLONES	53	$ 9,324.08	$ 175.93	70	26.3	53	100.00%
H7T	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAG	37513	$ 7,888,042.74	$ 210.27	51	24.4	34570	92.15%
H7U	ANTIPSYCHOTICS, DOPAMINE & SEROTONIN ANTAGONISTS	69	$ 5,528.98	$ 80.13	53	23.8	11	15.94%
H7X	ANTIPSYCHOTICS, ATYP, D2 PARTIAL AGONIST/5HT MIXED	4432	$ 1,379,339.54	$ 311.22	30	25.5	4432	100.00%
H7Z	SSRI &ANTIPSYCH,ATYP,DOPAMINE&SEROTONIN ANTAG COMB	75	$ 23,257.14	$ 310.10	35	31.2	75	100.00%

Antidepressants

Drug Therapeutic Class	Therapeutic Class Description	Number of Rxs	Amount Paid / Class	Average Cost/ Rx	Average Quantity/ Rx	Average Days Supply/ Rx	Certified Brand	% Brand Utilization
All		113133	$ 6,827,612.86	$ 60.35	41	29.7	47944	42.38%
H2S	SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS)	61681	$ 4,020,575.44	$ 65.18	37	30.0	33924	55.00%
H2U	TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB	11703	$ 141,189.16	$ 12.06	52	31.1	126	1.08%
H2W	TRICYCLIC ANTIDEPRESSANT/PHENOTHIAZINE COMBINATNS	58	$ 1,029.79	$ 17.76	68	32.5	36	62.07%
H2X	TRICYCLIC ANTIDEPRESSANT/BENZODIAZEPINE COMBINATNS	63	$ 2,938.36	$ 46.64	53	34.2	0	0.00%
H7B	ALPHA-2 RECEPTOR ANTAGONIST ANTIDEPRESSANTS	3872	$ 151,172.79	$ 39.04	30	27.5	121	3.13%
H7C	SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS)	10408	$ 1,324,034.50	$ 127.21	42	28.8	10408	100.00%
H7D	NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIB (NDRIS)	12395	$ 1,048,592.21	$ 84.60	49	29.5	3066	24.74%
H7E	SEROTONIN-2 ANTAGONIST/ REUPTAKE INHIBITOR	12865	$ 130,350.50	$ 10.13	44	28.4	175	1.36%
H7J	MAOIS - NON-SELECTIVE & IRREVERSIBLE	88	$ 7,730.11	$ 87.84	141	29.7	88	100.00%

CNS Stimulants

Drug Therapeutic Class	Therapeutic Class Description	Number of Rxs	Amount Paid / Class	Average Cost/ Rx	Average Quantity/ Rx	Average Days Supply/ Rx	Certified Brand	% Brand Utilization
All		23617	$ 2,224,608.23	$ 94.20	43	29.1	18719	79.26%
H2A	CENTRAL NERVOUS SYSTEM STIMULANTS	21	$ 971.77	$ 46.27	42	30.0	0	0.00%
H2V	TX FOR ATTENTION DEFICIT-HYPERACT(ADHD)/NARCOLEPSY	13227	$ 1,153,533.35	$ 87.21	43	29.0	9893	74.79%
H7W	ANTI-NARCOLEPSY & ANTI-CATAPLEXY,SEDATIVE-TYPE AGT	17	$ 7,558.16	$ 444.60	328	26.0	17	100.00%
H7Y	TX FOR ATTENTION DEFICIT-HYPERACT.(ADHD), NRI-TYPE	4280	$ 500,210.98	$ 116.87	40	29.8	4280	100.00%
J5B	ADRENERGICS, AROMATIC, NON-CATECHOLAMINE	6072	$ 562,333.97	$ 92.61	46	28.9	4529	74.59%

Antianxiety and Sedative Hypnotics

Drug Therapeutic Class	Therapeutic Class Description	Number of Rxs	Amount Paid / Class	Average Cost/ Rx	Average Quantity/ Rx	Average Days Supply/ Rx	Certified Brand	% Brand Utilization
All		43481	$ 1,107,392.89	$ 25.47	48	23.3	9203	21.17%
H2D	BARBITURATES	1538	$ 8,295.92	$ 5.39	102	28.7	934	60.73%
H2E	SEDATIVE-HYPNOTICS,NON-BARBITURATE	11705	$ 687,914.98	$ 58.77	31	25.5	7775	66.42%
H2F	ANTI-ANXIETY DRUGS	30238	$ 411,181.99	$ 13.60	53	22.2	494	1.63%

Mania

Drug Therapeutic Class	Therapeutic Class Description	Number of Rxs	Amount Paid / Class	Average Cost/ Rx	Average Quantity/ Rx	Average Days Supply/ Rx	Certified Brand	% Brand Utilization
H2M	ANTI-MANIA DRUGS	3186	$ 72,733.62	$ 22.83	81	27.4	468	14.69%

Anticonvulsants

Drug Therapeutic Class	Therapeutic Class Description	Number of Rxs	Amount Paid / Class	Average Cost/ Rx	Average Quantity/ Rx	Average Days Supply/ Rx	Certified Brand	% Brand Utilization
H4B	ANTICONVULSANTS	55813	$ 5,612,568.11	$ 100.56	87	27.4	26238	47.01%

Report
Health Access Oversight Committee
Pharmacy Benefit Management Program
Behavioral Health Drug Proposal
September 1, 2005
Attachment I
Proposed Behavioral Health Preferred Drug List and Drugs that Require Prior Authorization

Preferred Drug List and Drugs that Require Prior Authorization

Preferred	Therapeutic Class	Non-Preferred
Antidepressants - Novel		
Budeprion® (generic for Wellbutrin SR®)		Cymbalta® (duloxetine)
Buproprion (generic for Wellbutrin®)		Desyrel® (trazadone)
Buproprion SA (generic for Wellbutrin SR®)		Effexor® (venlafaxine)
Mirtazapine (generic for Remeron®)		Effexor XR® (venlafaxine ER)
Mirtazapine Rap Dis (generic for Remeron Sol-Tab®)		Remeron® (mirtazapine)
Nefazodone (generic for Serzone®)		Remeron Sol-Tab® (mirtazapine soluble tablet)
Trazadone (generic for Desyrel®)		Wellbutrin® (buproprion)
		Wellbutrin SR® (buproprion sustained release)
		Wellbutrin XL® (buproprion extended release)
Antidepressants - SSRI and Combos		
Citalopram (generic for Celexa®)		Celexa® (citalopram)
Fluoxetine (generic for Prozac®)		Lexapro® (escitalopram)
Fluvoxamine (generic for Luvox®)		Luvox® (fluvoxamine)
Paroxetine (generic for Paxil®)		Paxil® (paroxetine HCl)
		Paxil CR® (paroxetine HCl controlled release)
		Pexeva® (paroxetine)
		Prozac® (fluoxetine)
		Prozac Weekly® (fluoxetine)
		Sarafem® (fluoxetine)
		Symbyax® (olanzapine/fluoxetine)
		Zoloft® (sertraline)
Antidepressants - Tricyclic and MAOI		
	Tricyclic	
Amitriptyline (generic for Elavil®)		Elavil® (amitriptyline)
Clomipramine (generic for Anafranil®)		Sinequan® (doxepin)
Doxepin (generic for Sinequan®)		Tofranil® (imipramine)
Imipramine (generic for Tofranil®)		
Nortriptyline (generic for Aventyl®)		
Vivactyl® (protriptyline)		
	MAOI	
Nardil® (phenylzine)		
Parnate® (trancylpromine)		
Antihyperkinesis - ADD/ADHD; Narcolepsy: CNS Agents		
Adderall XR® (dextroamphet., IR/ER, 50:50%)		Adderall® (dextroamphetamine salts)
Amphetamine salt combo (generic for Adderall®)		Concerta® (methylphenidate IR/ER 22:78%)
Dextroamphetamine (generic for Dexedrine®)		Desoxyn® (methamphetamine)
Dextroamphetamine SA (generic for Dexedrine SA®)		Dexedrine® (dextroamphetamine)
Dextrostat® (generic for Dexedrine®)		Dexedrine Elixir® (dexedrine elixir)
Focalin® (dexmethylphenidate)		Dexedrine SA® (dexedrine sustained release)
Focalin XR® (dexmethlyphenidate, IR/ER, 50:50%)		Pemoline (Cylert®)
Metadate CD® (methylphenidate, IR/ER, 30:70%)		Provigil® (modafinil)
Metadate ER® (methlyphenidate ER)		Ritalin® (methylphenidate)
Methamphetamine (generic for Desoxyn®)		Ritalin SR® (methylphenidate sustained release)
Methylin® (generic for Ritalin®)		Strattera® (atomoxetine)
Methylin ER® (generic for Ritalin SR®)		
Methylphenidate (generic for Ritalin®)		
Methylphenidate SR (generic for Ritalin SR®)		
Ritalin LA® (methylphenidate, IR/ER, 50:50%)		
Antipsychotics - Atypical & Combinations		
Clozapine (generic for Clozaril®)		Abilify® (aripiprazole)
Risperdal® (risperdone)		Abilify® Oral Solution (aripiprazole oral solution)
Seroquel® (quetiapine)		Clozaril® (clozapine)
		Fazalco® (clozapine ODT)
		Geodon® (ziprasidone)
		Geodon IM® (ziprasidone Injectable)
		Risperdal Consta® (risperidone microspheres)
		Risperdal Tab Rapdis® (risperdone rapid dissolve tab)
		Symbyax® (olanzapine/fluoxetine)
		Zyprexa® (olanzapine)
		Zyprexa IM® (olanzapine injectable)
		Zyprexa Zydis® (olanzapine rapid dissolve tab)

Preferred Drug List and Drugs that Require Prior Authorization

Preferred	Therapeutic Class	Non-Preferred
Antipsychotics - Typical		
Chlorpromazine (generic for Thorazine®)		Haldol® (haloperidol)
Fluphenazine (generic for Prolixin®)		Loxitane® (loxapine)
Haloperidol (generic for Haldol®)		Mellaril® (thioridazine)
Loxapine (generic for Loxitane®)		Navane® (thiothixene)
Moban® (molindone)		Permitil® (fluphenazine)
Perphenazine (generic for Trilafon®)		Prolixin® (fluphenazine)
Thioridazine (generic for Mellaril®)		Serentil® (mesoridazine)
Thiothixene (generic for Navane®)		Stelazine® (trifluoperazine)
Trifluroperazine (generic for Stelazine®)		Thorazine® (chlorpromazine)
		Trilafon® (perphenazine)
Anxiolytics		
Alprazolam (generic for Xanax®)		Ativan® (lorazepam)
Buspirone (generic for Buspar®)		Buspar® (buspirone)
Chlordiazepoxide (generic for Librium®)		Klonopin® (clonazepam)
Clonazepam (generic for Klonopin®)		Klonopin Wafer® (clonazepam rapid dissolve tab)
Clorazepate (generic for Tranxene®)		Niravam® (alprazolam ODT)
Diazepam (generic for Valium®)		Tranxene® (clorazepate)
Lorazepam (generic for Ativan®)		Tranxene SD® (clorazepate sustained release)
Meprobamate (generic for Miltown®)		Xanax® (alprazolam)
Oxazepam (generic for Serax®)		Xanan XR® (alprazolam sustained release)
Mood Stabilizers - Antiepileptic and Anti-mania Drugs for Bipolar Disorder		
Carbamazepine (generic for Tegretol®)		Depakene® (valproic acid)
Depakote® (divalproex sodium)		Equetro® (carbamazepine SR)
Depakote ER® (divalproex sodium ext. release)		Eskalitlh® (lithium carbonate)
Depakote Sprinkle® (divalproex sodium capsule)		Eskalith CR® (lithium carbonate ER)
Gabapentin (generic for Neurontin®)		LithoBID® (lithium carbonate ER)
Lamictal® (lamotrigine)		Neurontin® (gabapentin)
Lithium Carbonate(generic for Eskalith®)		Tegretol® (carbamazepine)
Lithium Carbonate ER (generic for Eskalith CR®, LithoBID®)		Topamax® (topiramate)
Lithium Citrate Oral Liquid		Trileptal® (oxcarbazepine)
Valproic Acid (generic for Depakene®)		
Sedative Hypnotics		
Chloral hydrate (generic for Somnote®)		Ambien® (zolpidem)
Estazolam (generic for Prosom®)		Dalmane® (flurazepam)
Flurazepam (generic for Dalmane®)		Halcion® (triazolam)
Temazepam (generic for Restoril®)		Lunesta® (eszopiclone)
		Prosom® (estazolam)
		Restoril® (temazepam)
		Somnote® (chloral hydrate)
		Sonata® (zaleplon)
		Triazolam® (Halcion)
Xyrem®: Anti-narcolepsy/anti-cataplexy		
		Xyrem® (sodium oxybate)

Report
Health Access Oversight Committee
Pharmacy Benefit Management Program
Behavioral Health Drug Proposal
September 1, 2005
Attachment J
Proposed Behavioral Health Drug Class Clinical Criteria

Office of Vermont Health Access
Pharmacy Benefit Management Program
Clinical Criteria
Date: August 2005

Drug Class: **Central Nervous System Agents used in the treatment of Antihyperkinesis - ADD/ADHD; Narcolepsy**

Clinical alternatives: All medications used to treat this diagnosis are listed in this drug class.

	Issues Identified	Changes
	Stimulants	
1	► Age 3-18 exemption	► For all age groups, a therapeutic failure of preferred medication is a prerequisite to dispensing non-preferred medication.
2	► Medication trials	►A trial for efficacy of at least 2 preferred medications for at least 2 weeks each is required before authorization will be given for a non-preferred medication. The failure of a second preferred agent for the approval of Strattera® may not be required with appropriate documentation by the prescriber.
3	► Duplication of therapy: There is no evidence for the therapeutic use of duplicate medications from the stimulant class; however, multiple dosage forms of one medication and/or strengths may be used to meet a patient's needs. Therefore, no claims' edit for duplication of therapy will be used.	
4	► Dose optimization	► Every effort should be made to optimize doses to the least number of units / dose and maximize dosage intervals.
5	► Concerta®: currently grandfathered with review by DUR Board at the September 2006 meeting.	► Effective November 1, 2005 new patients taking Concerta® and those whose therapy has lapsed for 4 months will require a prior authorization. A therapeutic trial of a preferred agent is a prerequisite for PA.
6	► Current PA period is 6 months	► Extend PA period to 1 year

7	► Adjuvant treatments	► PA Clinical Criteria: ▪ Patients who are >/= 21 years of age ▪ Fatigue with cancer, HIV infection, traumatic brain injury or other debilitating condition.
Non-Stimulants		
1	►Criteria for age, therapeutic trials, duplications of therapy, dose optimization, lapse in therapy and use for adjuvant treatment also apply to non-stimulant medications.	
2	► Current PA period is 6 months	► Initial PA is 3 months, subsequently PA can be for 1 year.
3	► Provigil® (modafinil) Prior Authorization	► PA Clinical Criteria: ▪ Patients who are >/= 18 years of age ▪ Obstructive sleep apnea hypoapnea syndrome ▪ Fatigue in Multiple Sclerosis ▪ Narcolepsy for patients >/= 16 years or older
4	►Strattera® (atomoxetine) Prior Authorization	► PA Clinical Criteria: ▪ If the Physician states that there is a question of substance abuse with the patient or family, no failure of a stimulant is required to receive Strattera®. ▪ Dosage should not exceed 1.4mg/kg or 100mg/day.

References:

1. Treatment of Attention-Deficit/Hyperactivity Disorder: Overview of the Evidence Brown, et al, Pediatrics 2005; 115; 749-757
2. TIMA-Texas Implementation of Medication Algorithms, Texas Department of Health Services, 2003

Preferred Drug List:

Preferred	Therapeutic Class	Non-Preferred
Behavior Health - Antihyperkinesis (ADD/ADHD), Narcolepsy		
	Short Acting	
Dextroamphetamine (generic for Dexedrine®)		Desoxyn® (methamphetamine)
Dextrostat® (generic for Dexedrine®)		Dexedrine Elixir® (dextroamphetamine elixir)
Focalin® (dexmethylphenidate)		Dexedrine® (dextroamphetamine)
Methamphetamine (generic for Desoxyn®)		Ritalin® (methylphenidate)
Methylin® (generic for Ritalin®)		
Methylphenidate (generic for Ritalin®)		
	Intermediate Acting	
Amphetamine salt combo (generic for Adderall®)		Adderall® (dextroamphetamine salts)
Dextroamphetamine SA (generic for Dexedrine SA®)		Dexedrine SA® (dextroamphetamine sustained release)
Metadate ER® (methylphenidate ER)		Ritalin SR® (methylphenidate sustained release)
Methylin ER® (generic for Ritalin SR®)		
Methylphenidate SR (generic for Ritalin SR®)		
	Long Acting	
Adderall XR® (dextroamphetamine IR/ER, 50:50%)		Concerta® (methylphenidate IR/ER 22:78%)
Focalin XR® (dexmethylphenidate, IR/ER, 50:50%)		Pemoline (generic for Cylert®)
Metadate CD® (methylphenidate, IR/ER, 30:70%)		Provigil® (modafinil)
Ritalin LA® (methylphenidate, IR/ER, 50:50%)		Strattera® (atomoxetine)

Office of Vermont Health Access
Pharmacy Benefit Management Program
Clinical Criteria
Date: August 2005

Drug Class: Antipsychotics - Atypical Antipsychotics & Combinations

Clinical alternatives: The primary clinical alternative, the typical antipsychotics, are still utilized in selected interventions and settings.

	Issues Identified	Changes
1	► Generic preference	► When possible a generic medication must be trialed before a brand product is dispensed.
2	► Stage 1 Definition of an adequate trial	►An trial for efficacy, of a preferred agent would be defined as 4 weeks at a therapeutic dose or intolerance. ►In the case of Clozapine, titration to a therapeutic level may take a month and may require up to 3 months determining response.
A Prior Authorization is required to dispense a non-preferred agent before adequate trials of both preferred agents are attempted. A claims' look-back review will identify prerequisite trials. If absent, a message for PA will be sent to the pharmacy.		
3	► Stage 2 Agent selection	► After a trial of one preferred single AA agent at a therapeutic tolerated dose for 4 weeks, another preferred single agent within the class should be trialed.
4	► Stage 3 Agent selection	► If the second single agent trial of a preferred agent produces partial or no response, a trial of clozapine or if refused, another atypical agent is recommended.
5	► Stage 4 Agent selection	► If there is inadequate response to the trial of both preferred single atypical agents, the options are : ▪ to try the combination of a typical antipsychotics, another atypical agent or another drug class (mood stabilizers) or ▪ trial all available atypical agents before combination therapy is initiated.
6	► Maximum dose limits	► Dosages prescribed at >/= 25%* above the usual maximum recommended dose will required Prior Authorization for both preferred and non-preferred agents.
7	► Dose optimization	► Rational prescribing to maximize dose cost-efficiency should be considered. See ** below.

8	► Lapse in therapy of a non-preferred agent	► After a 4 month lapse in use of a non-preferred agent, or if there is a change in therapy, a look-back through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria. ►If there has been a trial of preferred agents, retrial is not necessary. ► If there has been a PA for Clozaril®, another PA is required.
9	►Specialty dosage forms	► Oral disintegrating and rapid dissolving tablets, oral solutions, IM injections or other special dosage forms require justification for authorization.

Atypical Antipsychotic Dosage Guidelines:

Atypical Antipsychotic	Starting Dose	Titration	Range	Maximum Dose	*PA is necessary for	Schedule
Risperidone	1-2mg/day	1mg every 2-3 days	2-6mg/day	6mg/day***	>/= 10mg/day	AM or HS**
Quetiapine	25mg bid	50mg/day	300-800mg/day	800mg/day	>/=1000mg/day	BID
Ziprasidone	40-80mg/day	20-40mg every 2-3 days	80-160mg/day	160mg/day	>/=200mg/day	BID
Olanzapine	5-10mg	5mg/week	10-20mg/day	40mg/day	>/=50mg/day	HS**
Aripiprazole	10-15 mg	After 2 weeks	10-30mg	30mg/day	>/=40mg/day	AM/HS **
Clozapine	12.5mg	Increase dose Every 3 days	300-900mg/day	900mg/day	>/=1125mg/day	BID (1/3 AM, 2/3PM)

*** The risk of EPS is significantly increased when doses >6mg are used.

[1] TIMA-Texas Implementation of Medication Algorithms, Texas Department of Health Services, 2003
[2] IPAP- International Psychopharmacology Algorithm Project, December 2004
[3] Oregon Evidence Based Practice Center, Drug Class Review, January 2005
[4] Veterans Administration PBM, Recommendations for Atypical Antipsychotic Use in Schizophrenia and Schizoaffective Disorders, May 2004
[5] Micromedex® Health Series, Thompson Healthcare, 2005.

PDL Medications:

Preferred	Non-Preferred
Clozapine (generic for Clozaril®)	Abilify® (aripiprazole)
Risperdal® (risperdone)	Abilify® Oral Solution (aripiprazole oral solution)
Seroquel® (quetiapine)	Clozaril® (clozapine)
	Fazalco® (clozapine ODT)
	Geodon® (ziprasidone)
	Geodon IM® (ziprasidone Injectable)
	Risperdal Consta® (risperidone microspheres)
	Risperdal Tab Rapdis® (risperdone rapid dissolve tab)
	Symbyax® (olanzapine/fluoxetine)
	Zyprexa® (olanzapine)
	Zyprexa IM® (olanzapine injectable)
	Zyprexa Zydis® (olanzapine rapid dissolve tab)

Office of Vermont Health Access
Pharmacy Benefit Management Program
Clinical Criteria
Date: August 2005

Drug Class: Antipsychotics – Typical

Clinical Alternatives: Atypical antipsychotics are often utilized when typical antipsychotics have induced adverse drug reactions or have not provided adequate response.

	Issues Identified	Changes
1	► Generic choices available	► A generic medication must be trialed before a brand product is dispensed.
2	► Definition of therapeutic failure	►A trial for efficacy of a preferred agent would be defined as 4 weeks at a therapeutic dose or intolerance.
3	► Agent selection	► After a trial of one preferred agent, maximum tolerated dose, another preferred agent within the class should be trialed.
A Prior Authorization is required to dispense a non-preferred agent before adequate trials of two preferred agents are attempted. A claims' look-back review will identify prerequisite trials. If absent, a message for PA will be sent to the pharmacy.		
4	► Use of duplicate therapies	► A duplication of therapy of medication within the same drug class will require PA after an 8 week (60 day) crossover period.
5	► Lapse in therapy for a non-preferred agent	► After a 4 month lapse in use of a non-preferred agent, or if there is a change in therapy, a look-back through claims information will identify the need to re-initiate therapy following the PDL and clinical criteria. ►If there has been a trial of preferred agents, retrial is not necessary.

[1] TIMA-Texas Implementation of Medication Algorithms, Texas Department of Health Services, 2003
[2] IPAP- International Psychopharmacology Algorithm Project, 2005
[3] Oregon Evidence-based Practice Center, Drug Class Review, 2005
[4] Veterans Administration PBM, Pharmacological Treatment of Major Depression in the Primary Care Setting, 2000.
[5] Micromedex® Health Series, Thompson Healthcare, 2005.

PDL Medications:

Preferred	Non-Preferred
Chlorpromazine (generic for Thorazine®)	Haldol® (haloperidol)
Fluphenazine (generic for Prolixin®)	Loxitane® (loxapine)
Haloperidol (generic for Haldol®)	Mellaril® (thioridazine)
Loxapine (generic for Loxitane®)	Navane® (thiothixene)
Moban® (molindone)	Permitil® (fluphenazine)
Perphenazine (generic for Trilafon®)	Prolixin® (fluphenazine)
Thioridazine (generic for Mellaril®)	Serentil® (mesoridazine)
Thiothixene (generic for Navane®)	Stelazine® (trifluoperazine)
Trifluroperazine (generic for Stelazine®)	Thorazine® (chlorpromazine)

Office of Vermont Health Access
Pharmacy Benefit Management Program
Clinical Criteria
Date: August 2005

Drug Class: Anxiolytics for the treatment of Anxiety

No Change in Existing Criteria

LENGTH OF AUTHORIZATION: 1 year

CLINICAL CONSIDERATIONS:

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:
- **Allergy** to medications not requiring prior approval.
- **Contraindication** to or drug-to-drug interaction with medications not requiring prior approval.
- **History** of unacceptable/toxic side effects to medications not requiring prior approval.

2. If there has been a **therapeutic failure to at least a one-week trial of at least two medications** not requiring prior approval, then may approve the requested medication.

DOCUMENTATION: Document clinically compelling information supporting the choice of a non-preferred agent through a **General Prior Authorization Request Form**.

PDL Medications:

Preferred	Non-Preferred
Alprazolam (generic for Xanax®)	Ativan® (lorazepam)
Buspirone (generic for Buspar®)	Buspar® (buspirone)
Chlordiazepoxide (generic for Librium®)	Klonopin® (clonazepam)
Clonazepam (generic for Klonopin®)	Klonopin Wafer® (clonazepam rapid dissolve tab)
Clorazepate (generic for Tranxene®)	Niravam® (alprazolam ODT)
Diazepam (generic for Valium®)	Tranxene® (clorazepate)
Lorazepam (generic for Ativan®)	Tranxene SD® (clorazepate sustained release)
Meprobamate (generic for Miltown®)	Xanax® (alprazolam)
Oxazepam (generic for Serax®)	Xanan XR® (alprazolam sustained release)

Office of Vermont Health Access
Pharmacy Benefit Management Program
Clinical Criteria
Date: August 2005

Drug Class: Mood Stabilizers - Antiepileptic and Anti-mania Drugs for Bipolar Disorder

Clinical Alternatives: All available non-barbiturate, non-benzodiazepine antiepileptic and anti-mania agents are included in this class.

	Issues	Criteria
1	► Generic Preference	► When possible, a generic medication must be trialed before a brand product is dispensed.
2	► Treatment Plans	► See Treatment Plan Grids.
3	► Preferred Drug List	► Propose that preferred medications be those for which there is an FDA approved indication for bipolar disorder and that non-preferred medications be those that are utilized, but not indicated for bipolar disorder.

[1] TIMA-Texas Implementation of Medication Algorithms, Texas Department of Health Services, 2003
[2] IPAP- International Psychopharmacology Algorithm Project, 2005
[3] Oregon Evidence Based Practice Center, Drug Class Review, 2005
[4] Veterans Administration PBM, Pharmacological Treatment of Major Depression in the Primary Care Setting, 2000.
[5] Micromedex® Health Series, Thompson Healthcare, 2005.

Drug Class: Mood Stabilizers- Antiepileptic and Anti-mania Drugs for Bipolar Disorder

PDL Medications:

Preferred Medications (FDA approved for bipolar disorder)		**Non-Preferred Medications Prior Authorization Required**
Generic	**Brand**	
First Line Agents		
Lithium Carbonate		Eskalith®
Lithium Carbonate SR		Eskalith CR®
		LithoBID®
Lithium Citrate Oral Liquid		
Valproic Acid		Depakene®
	Depakote®(divalproex sodium)	
	Depakote ER®	
	Depakote Sprinkle®	
Lamictal® (lamotrigine)*		
Second Line Agents		
Carbamazepine		Tegretol®
	Tegretol XR®	Equetro®
	Carbatrol®	
Gabapentin		Neurontin® (gabapentin)
		Trileptal® (oxcarbazepine)
		Topamax® (topiramate)

* PA required without a trial for efficacy of Lithium and Depakote® before step to Lamictal®.

OVHA **Proposed** **August 2005**

Bipolar Treatment Plans

Bipolar diagnosis	Feature	Preferred AAP treatment	Antimanic treatment*	Proposed Therapeutic Plans
Acute Manic or Mixed Episode				
	severe w/ psychosis	yes	yes	a combination of: 1. a preferred atypical antipsychotic **and** 2. concomitant antimanic therapy* should be tried
	no psychosis	yes, second line	yes	1. monotherapy with lithium or divalproex should be tried and failed, then 2. failure of both preferred AAPs, prior to approval for a non-preferred AAP**
Acute Depressive Episode				
	with psychosis	yes	yes	a combination of: 1. a preferred atypical antipsychotic, **and** 2. concomitant antimanic therapy should be tried
	severe depression w/no psychosis	yes, second line	yes	a combination of: 1. antimanic therapy, **and** 2. either buproprion or paroxetine failure, **then** 3. failure of both preferred AAPs, prior to approval for a non-preferred AAP
	less severe depression	yes, second line	yes	1. monotherapy with lithium or lamotrigine should be tried and failed, then 2. failure of both preferred AAPs, prior to approval for a non-preferred AAP
Maintenance				
	with psychosis	yes	yes	a combination of: 1. a preferred atypical antipsychotic, **and** 2. concomitant antimanic therapy should be tried
	no psychosis	yes, second line	yes	1. monotherapy with lithium or lamotrigine should be tried and failed, then 2. failure of both preferred AAPs, prior to approval for a non-preferred AAP

* Antimanic therapy = Antiepileptic Medications used in the Treatment of Bipolar Disorder

**AAP = Atypical Antipsycotic Medication, proposed OHVA preferred = Risperdal® (risperdone), Seroquel® (quetiapine)

Antiepileptic Drugs used in the Treatment of Bipolar Disorder

Place in therapy	Drug	FDA approved for Seizure Disorder	FDA approved for Bipolar Disorder	Bipolar Initial Daily Dose	Bipolar Usual Daily Dose	Bipolar Maximum dose(level)
First Line	Lithium (generic, Eskalith®, Eskalith CR®, LithoBID®)		yes	300-1200mg bid - tid	1200-2100mg qd-bid long term	(1.2 mEq/L)
	Valproate (generic, Depakene®)			20-30mg/kg load	20mg/kg = 1-3 gm/ day	
	Divalproex Sodium (Depakote®)	yes	yes			(125mg/ml)
	Lamotrigine (Lamictal®)	yes	yes, depression	25mg/dx2w, 50mg/dx2w, incr by 50mg/wk	200-400mg divided bid	600mg /day
Second Line	Carbamazepine (generic, Tegretol®, Carbatrol®, Equetro®)	yes	yes	200-600mg	600-1600mg divided bid-tid	
	Oxcarbazepine (Trileptal®)	yes		300-600mg	600- 2100mg divided bid	2400mg /day
Third Line	Topiramate (Topamax®)	yes		25mg	100-400mg divided bid	
Fourth Line	Gabapentin (Neurontin®)	yes				

Office of Vermont Health Access
Pharmacy Benefit Management Program
Clinical Criteria
Date: August 2005

Drug Class: Sedative Hypnotics (Non-Barbiturate)

No Change in Existing Criteria

LENGTH OF AUTHORIZATION: 1 year

CLINICAL CONSIDERATIONS:

1. Is there any reason the patient cannot be changed to a medication not requiring prior approval?

Acceptable reasons include:

- **Allergy** to medications not requiring prior approval.
- **Contraindication** to or drug-to-drug interaction with medications not requiring prior approval.
- **History** of unacceptable/toxic side effects to medications not requiring prior approval.

2. If there has been a **therapeutic failure to at least a one-week trial of at least one medication** not requiring prior approval, then may approve the requested medication.

DOCUMENTATION: Document clinically compelling information supporting the choice of a non-preferred agent through a **General Prior Authorization Request Form**.

PDL Medications:

Preferred	Non-Preferred
Chloral hydrate (generic for Somnote®)	Ambien® (zolpidem)
Estazolam (generic for Prosom®)	Dalmane® (flurazepam)
Flurazepam (generic for Dalmane®)	Halcion® (triazolam)
Temazepam (generic for Restoril®)	Lunesta® (eszopiclone)
	Prosom® (estazolam)
	Restoril® (temazepam)
	Somnote® (chloral hydrate)
	Sonata® (zaleplon)
	Triazolam® (Halcion)

Office of Vermont Health Access
Pharmacy Benefit Management Program
Clinical Criteria
Date: August 2005

Drug Class: Xyrem®: Anti-Narcolepsy/Anti-cataplexy

Clinical alternatives: CNS stimulant (amphetamine, dextroamphetamine or methylphenidate for sleep attacks and TCA antidepressants for cataplexy/sleep paralysis).

Proposed Criteria (to be reviewed by DUR Board in September 2005):

	Issues Identified	Proposed Criteria
1	► Sodium oxybate has not been proven superior to current standards of treatment. It is considered a second line agent.	► Prescriber must demonstrate failure of all treatment alternatives before prior authorization will be given for Xyrem®.
2	► Treatment failure definition.	► Patient cannot tolerate the side effects of TCAs or have become tolerant or unresponsive to TCAs or CNS stimulants.
3	► Tolerance does not appear to develop with Xyrem®.	► Dose is weight based, 50mg/kg, given once at bedtime, then 3-4 hours later. Weight will be required at time of PA and for all subsequent PA. Specific quantity per month will also be determined.
4	► Drug misuse and abuse potential. Otherwise know as the 'date-rape' drug.	► This drug is contraindicated with the use of sedative hypnotics, alcohol, sleep apnea and due to its sodium content with cardiac failure compromised renal function and hypertension. ► Xyrem® is a Schedule III controlled substance, available only through restricted distribution, the Xyrem Success Program (1-866-997-3688).

PDL Medications:

Preferred	Non-Preferred
	Xyrem®

Report
Health Access Oversight Committee
Pharmacy Benefit Management Program
Behavioral Health Drug Proposal
September 1, 2005
Attachment K
Sample Dose Consolidation Pricing

Frequently Used Behavioral Health Drugs

Product	Stength	Cost/unit
Lunesta	1mg, 2mg, 3mg	$3.70
Geodon	20mg, 40mg	$5.13
	60mg, 80mg	$5.59
Zoloft	25mg, 50mg, 100mg	$3.01
Zyprexa	2.5mg	$6.46
	5mg	$7.63
	7.5mg	$9.28
	10mg	$11.50
	15mg	$17.25
	20mg	$22.97